The Quality and Outcomes Framework as a Biomedical Technology: Consequences for UK General Practice

NORMAN, ARMANDO,HENRIQUE

DURHAM UNIVERSITY DEPARTMENT OF ANTHROPOLOGY

THE QUALITY AND OUTCOMES FRAMEWORK AS A BIOMEDICAL TECHNOLOGY: CONSEQUENCES FOR UK GENERAL PRACTICE

Armando Henrique Norman
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Supervisors: Dr. Andrew J. Russell
Dr. Claudia Merli

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Abstract

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In April 2014 the Quality and Outcomes Framework (QOF), the largest pay-for-performance scheme in primary care in the world, completed 10 years of existence. During this period, medical anthropologists have given little attention to QOF as a biomedical technological innovation for improving quality in general practice. This thesis contributes to the study of biomedical technology in medical anthropology by exploring two questions. First, what QOF in itself entails, its main characteristics and boundaries? Second, what are its consequences for general practice and for professional staff? An ethnographic study was set up to explore the QOF 2013/14 contract year in two general practices in the UK, coupled with participant-observation in a GP training programme. The main findings can be summarised as follows: (1) based on Foucault's concept of governmentality, QOF as a biomedical technology represents a biopower *dispositif* for controlling individual (anatomopolitics) and population (biopolitics) by instilling a self-monitoring professional working environment for securing compliance; (2) the QOF clinical fragmentary model based on monetary incentives has literally commodified health professional-patient relationships through an exchange of token-information predicated on patients' bodily parts. In this quality scheme, commercial ethics tend to predominate over professionals' ethics; (3) the QOF scheme has produced a series of behaviour ranging from organising the practice team in accordance to QOF's rules (the 'QOF game') to 'gamesmanship' with regards to them. The latter is more common as the practice reaches the end of financial year. These behaviours have implications for quality data production, affecting research on QOF, since most of it depends on secondary data sources; (4) in following the QOF depression indicators as a 'mediating category' since their inception in 2006/07, the question of 'quality' indicator construction and data production is further highlighted. QOF as a biomanagerial technology exemplifies an important cultural change in the UK general practice since compliance with externally dictated policy and its associated technologies changes principles and behaviour, with little scope for a holistic practice.

Keywords: Anthropology; Pay for Performance; Biomedical Technology Assessment; General Practice; Great Britain.

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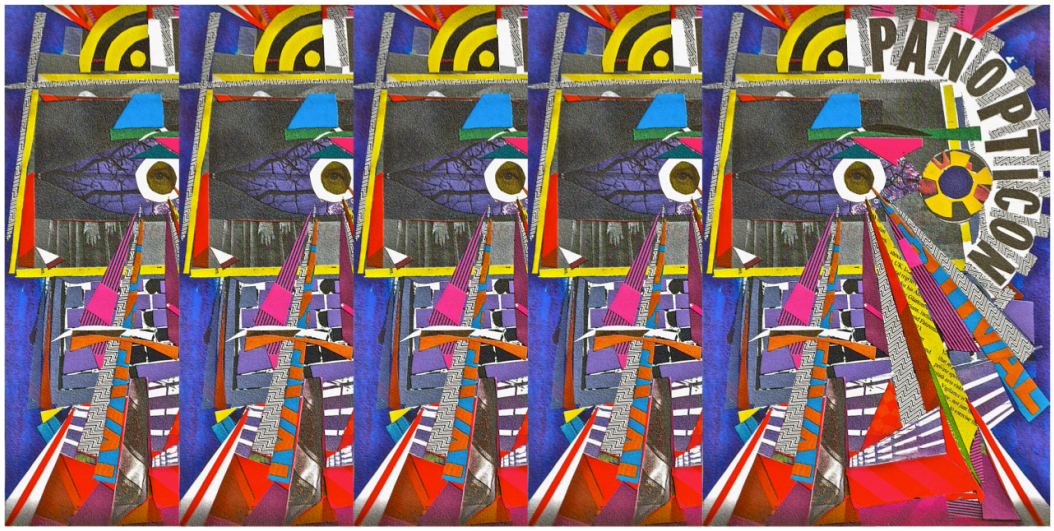

‘Panopticon’. Josane Norman, 2015.

Table of Contents

List of Tables

List of Figures

List of Graphs

List of Abbreviations

A&E	Accident and Emergency
AKT	Applied Knowledge Test
ASA	Association of Social Anthropologists
BDI-II	Beck Depression Inventory Second Edition
BJGP	British Journal of General Practice
BMA	British Medical Association
BMJ	British Medical Journal
CAG	Confidentiality Advisory Group
CAM	Complementary Alternative Medicine
CCG	Clinical Commissioning Group
CHI	Commission for Health Improvement
CQC	Care Quality Commission
CSA	Clinical Skill Assessment
CTF	Canadian Task Force
DoH	Department of Health
DQM	Depth of Quality Measurement
EBM	Evidence-Based Medicine
EMs	Explanatory Models
EPRs	Electronic Patient Records
FAQs	Frequently Asked Questions
FP	Foundation Programme
GMS	General Medical Service
GMSC	General Medical Service Committee
GPs	General Practitioners
GPS	General Practice Surgery
GPST	GP Specialty Training
GPTP	GP Training Programme
HADS	Hospital Anxiety and Depression Scale
HDR	Half-Day Release
HEE	Health Education England
HSCIC	Health & Social Care Information Centre
IOM	Institute of Medicine
IT	Information Technology
MS	Managerial Staff
MPIG	Minimum Practice Income Guarantee
MS	Medical Services
NAO	National Audit Office
NHS	National Health Service
NICE	National Institute for Health and Care Excellence

NSC	National Screening Committee
NSFs	National Service Frameworks
OECD	Organisation for Economic Cooperation and Development
PCT	Primary Care Trust
P4P	Pay-for-Performance
PH	Public Health
PHC	Primary Health Care
PMS	Personal Medical Service
QOF	Quality and Outcomes Framework
RCGP	Royal College of General Practitioners
REC	Research Ethics Committee
SAQ	Severity-Assessment Questionnaire
SPN	Selection from the Prison Notebooks
SUS	Brazilian Unified Health System (Sistema Único de Saúde)
UK	United Kingdom
US	United States
USPSTF	US Preventive Service Task Force
WHO	World Health Organisation
WWII	World War II

List of Medical Term Abbreviations

A&D	Alcohol and Drug
AF	Atrial Fibrillation
BMI	Body Mass Index
BPA	Biopsychosocial Assessment
BP	Blood Pressure
CHD	Coronary Heart Disease
CKD	Chronic Kidney Disease
COPD	Chronic Obstructive Pulmonary Disease
CVD	Cardiovascular Disease
CVD-PP	Cardiovascular Disease – Primary Prevention
DM	Diabetes Mellitus
DNA	Did Not Attend
ED	Erectile Dysfunction
FRAX	Fracture Risk Assessment Tool
FVE1	Forced Expiratory Volume in the first second
GPPAQ	GP Physical Activity Questionnaire
HbA1c	Haemoglobin A1c
HMG-CoA	3-hydroxy-3-methylglutaryl-coenzyme reductase
HRSD-17	Hamilton Rating Scale for Depression
HYP	Hypertension
JBS2	Joint British Society 2
LARC	Long-Acting Reversible Contraception
LD	Learning Disabilities
LVD	Left Ventricular Dysfunction
MI	Myocardial Infarction
MS	Multiple Sclerosis
NNT	Number Needed to Treat
PAD	Peripheral Arterial Disease
PC	Palliative Care
PHQ-2	Patient Health Questionnaire-2
PHQ-9	Patient Health Questionnaire-9
QRISK®2	Cardiovascular Risk Calculator
RA	Rheumatoid Arthritis
SSRI	Selective Serotonin Re-Uptake Inhibitors
STIA	Stroke and Transient Ischaemic Attack
TIA	Transient Ischemic Attack
TSH	Thyroid Stimulant Hormone

Transcription Notation and Conventions

Symbol	**Meaning**
…	Short, untimed silence (micro-pause), generally less than two-or three-tenths of a second
[ ]	Beginning ([) and end (]) of overlapping talk
((coughing))	Nonverbal expressions
hmm, mm	Hesitation marks
It was pos#	Interruptions
.hh	Audible in-breath. Longer sounds are transcribed using a longer string: .hhhh
hh	Outbreath.
It was *really* important.	Vocal stress or emphasis.
(Fair?); This is a (rehash).	Words or expressions, which cannot be easily recognised.

Source: adapted from *The Interview: An Ethnographic Approach*, Ed. Jonathan Skinner, London: Berg, 2012.

Declaration

I declare that all the material contained in this thesis is my own work.

Dedication

To Josane Norman

Acknowledgments

Being accepted into two general practice medical groups to conduct research on UK general practice was the most gratifying moment in my PhD endeavour. This made all the difference. I must thank the GPs and members of staff of the GP training programme for welcoming and allowing me taking part in their activities. Through them I have learned a lot about general practice in the UK. In both GP surgery groups I was welcomed and they were very friendly, patient, and provided a space for a good conversation and exchange of ideas and friendship. I am very thankful for all the practice teams in giving me the chance to carry out this research. They are really committed with delivering a good health service and, thanks to their commitment the NHS is an excellent health system.

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Chapter One

INTRODUCTION

In 2004 the Quality and Outcomes Framework (QOF) was introduced into general practice in the United Kingdom (UK) as part of a new contract celebrated between the government and general practitioners (GPs). The QOF scheme is a pay-for-performance modality aiming to improve quality of care in general practice according to pre-established clinical targets. Since this biomedical technological innovation is considered the largest of its kind in the world, it has caught the attention of both researchers and family doctors internationally (Roland, 2004). Additionally, the National Health Service (NHS) has an outstanding reputation worldwide as a public funded health system free at the point of delivery (McCarthy, 2014). Thus, this context provided the stimulus for me, a Brazilian GP, to cross the Atlantic to study 'the other's' interesting health culture and practice via its technological innovations.

This introductory chapter briefly contextualises the research environment, i.e. the primary health care sector within the NHS. Then, it turns to the subject of biomedical technology and its importance to medical anthropology, followed by a presentation of the research aims and objectives, and finally an outline of the thesis chapters' content.

PRIMARY HEALTHCARE: THE BEDROCK OF A NATIONAL HEALTH SYSTEM

The history of anthropology as a discipline is marked by a general trend to study other cultures, primarily in middle- to low-income countries, such as former Western colonies (Crehan, 2002). Hence, ethnographic studies usually first present the historical, political, economic and cultural contexts of a chosen research site in a country. Ethnographies commonly explain the reason for studying a particular community, village or institution in that country. However, this research focuses on a biomedical technological innovation that was applied nationally in UK general practice. Thus, it seems a better approach to contextualise primary health care in the UK, which essentially strengthened general practice as a distinctive branch in medicine, as discussed in Chapter Two.

Historically, the term primary health care was firstly officially established in the UK in 1920 with the Dawson Report (Starfield, Shi, & Macinko, 2005). As the report states:

> A Health Centre is an institution wherein are brought together various medical services, preventive and curative, so as to form one organisation. Health Centres may be either Primary or Secondary, the former denoting a more simple, and the latter a more specialised service. (Dawson, 1920, item 9)

This report underpins the very conception of the NHS, which was put on hold due to World War II (WWII). In fact, the Dawson Report was a blueprint for how to organise rationally health service provisions and resources based on the principle of regionalisation (health districts) and hierarchisation (primary, secondary, and tertiary care levels), as follows:

> The domiciliary services of a given district would be based on a *Primary Health Centre* an institution equipped for services of curative and preventive medicine to be *conducted by the general practitioners of that district* [emphasis added], in conjunction with an efficient nursing service and with the aid of visiting consultants and specialists. (Dawson, 1920, item 10)

Therefore, since the initiation of a national health system, general practitioners have been positioned at the primary care level as coordinating patients' care and access to other levels of the health system. In contrast with what was being devised in the UK, in the US (United States) the trend was to specialise and to produce experts in specific systems or parts of the body (Beck, 2004). This trend was reinforced after the WWII, with most general doctors being stimulated to become specialists (Starfield et al., 2005). Thus, in the US, the survival of generalists (family doctors) as a specialised branch of medicine relied on the enthusiasm of professionals concerned with the future of family medicine in that country. Thanks to the enthusiasm of American physicians, their effort eventually unfolded into post-graduation training programmes in 1960s and 1970s. In this context, there was a need for defining primary care, because family physicians were regarded as specialists in working at the primary care level (McWhinney & Freeman, 2009). In 1978, the Institute of Medicine (IOM) defined primary care as a place for:

> The provision of *integrated*, *accessible* health care services by clinicians who are accountable for *addressing a large majority* of personal health care needs, *developing a sustained partnership with patients* [emphasis added], and practicing in the context of family and community. (Starfield et al., 2005, p. 458)

This definition is still valid, since it comprises the four pillars for measuring primary care quality: 'first-contact access for each new need; long-term person- (not disease) focused care;

comprehensive care for most health needs; and coordinated care when it must be sought elsewhere' (Starfield et al., 2005, p. 458). Hence, through different routes (more organisational in the UK and more conceptual in the US) primary care became the working environment of general practitioners or family doctors.

The primary care concept would eventually receive further definition and support in the International Conference on Primary Health Care, Alma-Ata, in 1978. In the Alma-Ata declaration, primary care definition gave a special attention to developing countries and the need to foster a more comprehensive approach to health that would take into account the social determinants of health. For instance, it states that primary care should entail 'education concerning prevailing health problems and the methods of preventing and controlling them; promotion of food supply and proper nutrition; an adequate supply of safe water and basic sanitation' (Alma-Ata, 1978, VII item 3). Certainly, these issues are important for health promotion, however health services should have a complementary role within a more coordinated intersectoral approach to the population overall well-being.

The Alma-Ata declaration contributed to the development of primary health care as well as giving importance to other sectors of society for promoting a healthy environment 'underpinned by social justice, equity, and solidarity' (Rawaf, De Maeseneer, & Starfield, 2008, p. 1). The creation of the NHS was based on these very principles as stated by its founder Health Minister Aneurin Bevan: "We ought to take pride in the fact that, despite our financial and economic anxieties, we are still able to do the most civilised thing in the world - put the welfare of the sick in front of every other consideration" (cit. in Heath, 2007, p. 19).

Built in the post-war time, the NHS represents the solidarity spirit of a nation that choose to have a universal health system based on strong primary care services, within which general practice has a central role. Additionally, the existing accumulative evidence suggests that countries with a similar approach have better health systems. For instance, since 2004 when the Commonwealth Fund started to compare health systems of the 11 countries of the Organisation for Economic Cooperation and Development (OECD), the US has ranked as last despite expending per capita 2.5 times more than the UK, which is positioned at the top of the ranking (Davis, Stremikis, Squires, & Schoen, 2014). Therefore, since the inception of the NHS, in 1948, its fundamental principles have survived in spite of the all-important political and organisational changes required to run a national health system effectively.

Although making an important contribution to populations' health, the health sector accounts for a small input on the countries' overall health achievement. As the World Health Organisation-WHO (2009, p. 1) highlights 'health promotion is not just the responsibility of the health sector, but goes beyond healthy life-styles to well-being' which includes 'social justice and equity'. Taking a broader perspective on health, the UK, despite having the best health system in the world, does not have best health outcomes within the same OECD countries (Wilkinson & Pickett, 2010, p. 20). In fact, apart from the US, which notably ranks at the bottom in all health indicators, the Scandinavian countries come as the first in all major health indicators. For instance, infant mortality in Sweden is 2.3 per 1000 live births, whereas in the UK is 4.3 per 1000 (OECD, 2013).

Therefore, the object of the present research should be placed in relation to both a high quality standard health system and health indicators. The technological innovation to be considered aims to further improve the quality of the health service being delivered at primary care level that has traditionally enjoyed a good reputation worldwide.

ANTHROPOLOGY OF BIOTECHNOLOGY

Various approaches might inspire researchers to address or reflect on the theme of technology. Commonly, anthropologists tend to study and research technology in the 'doing', i.e. ethnographically explore its cultural and social-economic reality. In other words, we want to observe, we want to participate and, to some extent, engage with people's environment and 'tools'. Usually, two interconnected dimensions can be explored: one that is hidden, subjective, phenomenological (the reflective experience 'behind the eyeballs'), and other that is explicit, visible, material and social – the space beyond perception 'in front of the eyeballs' (Katz & Csordas, 2003, p. 278).

However, anthropologists should also consider the ontological dimension. According to Weiner (1992, p. 77) an ontological approach would imply an 'excavation of epistemology, a cataloguing of steps that are taken and the assumptions made to get to a particular view of the things'. His provocation stems from Heidegger's ontological enquiry, which is relevant for anthropology's philosophy and ethnography. For instance, what is it that makes modern technology so distinctive? What is the essence of technology that makes it so attractive, powerful, and useful in the current socioeconomic and political context? Thus,

anthropologists should question some of the prior assumptions about the research object before going into the practice or the study of any phenomenon.

In regards to QOF, its complexity requires an approach informed by distinct interconnected theoretical stances. For instance, Heidegger's critique of modern science technologies has parallels with biomedicine's fragmentary approach to the body and life itself. As he remarks '*episteme*' and '*techne*' are words that share the same meaning: 'knowing in the widest sense' (Heidegger, p. 13). From epistemological, historical, sociological and political perspectives, Bruno Latour's concept of 'actor-network' could be an alternative path to address QOF as a biomedical technology (Latour, 2005). There is an increased recognition that these perspectives are in a complex intertwined relation with human and non-human 'actors' that stabilise our social and cultural environment. However, taking this direction would imply a detailed exploration of the QOF in its construction and stabilisation, in terms of its complex hybrid composition, involving human and nonhuman actors. This would risk divert the research focus away from the daily reality of GPs. Thus, the present research opted for a theoretical construct that is more aligned with the complexity of the research object in terms of its effects to general practice.

As QOF merges into general practice work environment, different theoretical approaches need to be applied in order to shed light on QOF as a biomedical technology, concerning power relations and working conditions that practice teams find themselves in. For instance, the Gramscian concept of hegemony is a powerful framework to tackle the body/state dialectical relationship and the cultural changes that have occurred in general practice in the UK. According to Pizza (2012, p. 96), Gramsci's approach to the 'sphere of life and that of politics' has a close link with Foucault's concept of biopolitics. As the NHS represents an important social asset in the art of governing individuals and population health, Foucault's concept of governmentality has naturally become the bedrock for analysing QOF.

Nonetheless, when faced with the theme of health commodification, renowned scholars in anthropology such as Scheper-Hughes, Cohen, Lock, and Sharp have addressed body-part commodification processes in light of a Marxist theory of commodification. Additionally, the intense marketisation in the NHS and the need to dialogue with all these scholars led me to follow Nikolas Rose's approach to biopower as source of biocapital. By finding commonalities within a range of theories and connecting them with the empirical

research material it was possible to bring together Heidegger's concept of nature as 'standing-reserve' and health commodification. This helped to shed light on QOF's economic gains and political utility as a biomedical technology for the UK bioeconomy.

Mastering the natural world

This subheading pays tribute to Lock and Nguyen's seminal book on the anthropology of biomedicine. The authors clearly state that 'political and medical interest' as well as 'cultural norms' tamper the usage of biomedical technologies that goes beyond the medical practice, since it is underpinned 'by overarching ideas about the most promising directions for progress and mastery of the natural world' (Lock & Nguyen, 2010, p. 17). This idea of 'mastery of the natural world' speaks of a period in Western history, which started towards the end of the sixteenth century with the rise of modern science. Its most significant implication was for people's mentality:

> The new mentality is more important even than the new science [modern science] and new technology [modern technology]. It has altered the metaphysical presuppositions and imaginative content of our minds; so that now old stimuli provoke a new response. (Whitehead, 1967, p. 2)

Taking a similar approach in his inquiry on modern technology, Heidegger clarifies that the essence of technology is nothing technological. This new mentality, according to him, accounts for the essence of modern technology. For Heidegger, 'man's ordering attitude and behaviour display themselves first in the rise of modern physics as an exact science. Modern science's way of representing *pursues and entraps nature as a calculable coherence of forces*' [emphasis added] (Heidegger, 1977, p. 21). This power of separating, isolating, measuring, classifying, calculating, and organising is what renders technology its political utility. Thus, the essence of modern technology lies in this particular way of revealing nature 'in the mode of ordering, as standing-reserve' (Heidegger, 1977, p. 20).

Derived from the German word *'bestand'*, standing-reserve means 'stock', i.e. 'being available to serve some end that will itself also be directed towards getting everything under control', (Lovitt, 1977, p. xxix). According to Heidegger, modern technology frames nature in a way that challenges its capacity to 'supply energy' that can be 'extracted and stored as such' (Heidegger, 1977, p. 15). This ordering, organising, and controlling (including population, individuals, and bodies) that portrays nature as a 'standing-reserve' is what has

made scientific technology attractive and useful for a capitalist economic model. As Whitehead (1967, p. 4) states 'there can be no living science unless there is a widespread instinctive conviction in the existence of an Order of Things, and in particular, of an Order of Nature'. But the new thing about modern science is its 'interest in the relation of general principles to irreducible and stubborn facts' (*ibid* p. 3). Shedding light on the ontological aspect of modern technology might contribute to better understanding its material, cultural, and social realities.

Sociotechnical System

Bryan Pfaffenberger suggests that anthropologists should approach technology as a sociotechnical system. The author defines this as 'the distinctive technological activity that stems from the linkage of techniques and material culture to the social coordination of labour' (Pfaffenberger, 1992, p. 497). This approach challenges the standard view of technology, which tends to deny technology's social aspects by taking out the power relation, the material meaning and its application in particular settings (Greenhalgh & Swinglehurst, 2011). Pfaffenberger (1988) accuses the standard view's denial of sociality as being either somnambulistic or deterministic. The former sees technology as 'morally and ethically "neutral". It is neither good nor bad, and its "impact" depends on how it is used' (Pfaffenberger, 1988, p. 238). The latter sees technology 'as a powerful and autonomous agent that dictates the patterns of human social and cultural life […within] which people have been little more than helpless spectator' (Pfaffenberger, 1988, p. 239). These naïve and positivistic approaches to technology tend to simplify it into a making-user tool relationship, emptied of its social content, to be treated as a mechanical matter. This approach generates technological 'fetishized forms: what is in reality produced by relations among people appears before us in a fantastic form as relations among things' (Pfaffenberger, 1988, p. 242).

Thus, by questioning the standard view of technology, Pfaffenberger (1992, p. 505) brings to centre stage the political dialectical nature of technology portrayed as technological drama characterised by a 'statement' and 'counter-statement' discourse clash. This technological drama is particularly true in biomedicine and its relation with other medical rationalities such as homoeopathy, acupuncture, and the like. In other words, biomedicine has become the hegemonic discourse on the truth of scientific fact and authority over human life

(Barry, 2006). According to Gramsci, hegemony as a dialectic process entails mechanisms of 'coercion and consent' (SPN: 80, cit. in Crehan, 2002, p. 104). An example of this hegemonic discourse concerns the rise of Evidence-Based Medicine (EBM) as almost a 'juridical instrument' (the 'gold standard'), which is used both as a base for a strong clinical governance framework (coercion) and best practice model in medicine (consent). Hence, biomedical technology speaks directly of power and, consequently, leads to the theme of 'power over life' or, more precisely, biopower technologies.

Biopower: biomedicine as technology

Biomedicine as technology casts a particular gaze over human beings, which tends to reduce life (bios – life as existential, relational and political) into bodily functions (zoe – animal life or bare life) (Rose, 2006). This reductionism of the biomedical model, with a focus on physiochemical bodily mechanisms, has important consequences for the approach to health. Firstly, as a hegemonic explanatory model of the health/disease phenomenon, it tends to conceptualise the human body as a homogeneous, standardised, and objective reality (Lock & Nguyen, 2010). Secondly, its reductionist view drives the attention of policy-makers and the public away from the social determinants of health, diverting the available public resources into health policies that privilege corporations of the pharmaceutical-industrial complex (Bayer & Galea, 2015). Thus, biopower technologies push the boundaries of biomedicine as a sociotechnical system immersed in a complex neoliberal bioeconomy.

Biopower technologies change the relationship between man and nature, making life itself amenable to exploitation. As Nikolas Rose (2006, p. 38) states, humans' and other beings' vitality can be now 'decomposed into a series of distinct and discrete objects that can be stabilised, frozen, banked, stored, accumulated, exchanged, traded across time, across space, across organs and species, across diverse contexts and enterprises, in the service of bioeconomic objectives'. In this regard, the human body can also be seen as a 'standing reserve', a storehouse of bio-values.

Historically, biopower technologies became central in the art of governing, as Europe moved from a ruling sovereign system into a government state system for controlling geographic areas. In the sixteenth century, with the Reformation and start of Enlightenment,

important changes occurred in the geography, economy, and political landscape of Europe. As Whitehead (1967, p. 1) states 'the sixteenth century of our era saw the disruption of Western Christianity and the rise of modern science. It was an age of ferment. Nothing was settled, though much was opened - new worlds, new ideas'. In the art of government a new rationality was needed, as Michel Foucault (1991a, p. 88) remarks: there was 'a double movement, then, of state centralisation on the one hand and of dispersion and religious dissidence on the other'. In this context, there was a need for a 'secular political pastorate', a form of governing that was both individualising and totalising (Gordon, 1991, p. 8).

According to Foucault (1991a, p. 93), in the sixteenth century a different process of power relation started as Europe moved towards a state system of governing. It meant a new approach to the 'men' and 'things' in the territory. Previously, the king's power and territory were predicated on his extrinsic relation with other monarchs, as well as on his intrinsic family heritage and succession. There was no 'essential, natural or juridical connection between the prince and his principality' (Foucault, 1991a, pp. 89 - 90) However, as the feudalistic model succumbed, merging into bigger concentrations of people and material production, new ruling forms of governance came in to existence. In this context, 'men' and 'things' became the central object of control as the West moved into capitalist modes of production. In this new economic system, the sovereign power to seize life was transformed into ways of administering, controlling, disciplining, and optimising life. As Foucault (1978, p. 136) remarks 'death that was based on the right of the sovereign is now manifested as simply the reverse of the right of the social body to ensure, maintain, or develop its life'. Based on Foucault's concept of techniques of power, Lock and Nguyen (2010, p. 24) highlight the:

> Gradual emergence and regularization from the 18th and 19th centuries onward of state-controlled, systematically organized institutions - schools, the army, prisons, the family, hospitals, clinics, and other units for the administration of collective bodies. He [Foucault] described these changes in social organization as the formation of "biopower," central both to the emergence of capitalism and to the "controlled insertion of bodies into the machinery of production".

This biopower technology - applied to 'each and all' as a disciplinary *dispositif by* means of different institutions - has become the hegemonic way of addressing individual and collective issues. In this process, biomedicine has expanded its jurisdiction, authority, and practice

encompassing great portions of human beings' every-day life behaviours, struggles, and problems as a medical matter, a process called medicalisation (Conrad, 1992). However, Clarke, Shim, Mamo, Fosket, and Fishman (2003) propose that biomedicalisation is a more appropriate term than medicalisation reflecting the advent of information technology systems (computer-based research and record-keeping) and the availability of new biotechnological innovations at institutional and organisational meso-level. In this regard, the authors argue that:

> The scope of biomedicalisation processes is thus much broader, and includes conceptual and clinical expansions through the commodification of health, the elaboration of risk and surveillance, and innovative clinical applications of drugs, diagnostic tests, and treatment procedures. (Clarke et al. 2003, p. 165)

Thus, in postmodern society where deregulation, competition and devolution are the cornerstones of the neoliberal globalised economy, IT systems are increasingly having a fundamental role in strengthening Foucault's fluid concept of biopower. Paradoxically, the more the macroeconomic level valorises entrepreneurism and 'risk-taking', the greater the need for control, standardisation, and measurements at the meso- and micro-levels, potentially furthering the medicalisation process (i.e. biomedicalisation). As Turner (1997, p. xviii) states the more 'the global economy develops into a culture of risk, the nation state is forced to invest more and more in internal systems of governmentality'.

Foucault's concept of governmentality, which encompasses biopower as disciplinary technologies, provides a powerful theoretical framework for both scholars and researchers interested in biotechnology or biomedicine as technology. I shall use Foucault's concepts and ideas on biopower as an analytical tool to study the QOF scheme, a biomedical technology implemented at the meso- and micro institutional level of UK general practice.

RESEARCH GENERAL AND SPECIFIC OBJECTIVES: CONTRIBUTIONS TO ANTHROPOLOGY OF BIOMEDICAL TECHNOLOGY

The general objective of this research is to explore the consequences of the Quality and Outcomes Framework (QOF) for primary health care professionals (its influences on work practice and the dynamics of professional interactions) and specifically, how the QOF has affected general practitioners' principles and practice, such as holism, patient-centeredness,

continuity of care, and so on. Therefore, by providing an ethnographic study focussing on the QOF, the aim of this research is to expand knowledge of biomedical technology in general, and simultaneously, make a unique contribution to the growing field of anthropology of biomedical technologies. In this regard, Foucault's concept of biopower as an important analytical tool for addressing current biotechnological innovations might critically inform policy-makers about the unintended consequences of pay-for-performance strategies.

In order to narrow down the enquiry, the first step is to reflect on what QOF entails and how does it operate as a biomedical technology. As QOF relies on information technology (software and hardware), to understand how the information technology (IT) system merges into general practice and affects the day-to-day care provisions has become very relevant. In other words, what are the characteristics of the system of practice which QOF organises? For example, what are the 'scripts' - standard operating procedures, moves, rules-of-thumb, know-how, judgements, assumptions and the like, associated with QOF requirements in practice?

The innovation linked to this reimbursement system concerns monetary incentives attached to clinical criteria and standards within a financial calendar year. The main questions that arise are: what are the effects that monetary incentives have on professional staff? How do they perceive the monetary incentive attached to QOF? As traditionally general practice would rely on longitudinal care based on multiple encounters to reach a clinical objective, does the QOF's spatial and temporal framework have the potential to change practices' behaviour?

Lastly, taking the overall impact of QOF on general practice, one might enquire if QOF has changed UK general practice's culture? If so, in what ways have professionals' roles, identities, relationships, and work practices have changed? Do these changes have any detrimental effect upon patients? These are questions to be answered by engaging both with the literature and the empirical material produced through this research on QOF as a biomedical technology.

THESIS OUTLINE

The study of technology, and in particular biomedical technologies, poses an intellectual challenge to a researcher who usually has to overcome its apparent aridity, dryness and sometimes, its intellectual monotony (Pfaffenberger, 1992). The way to make it more

attractive to the field of anthropology was to keep a close touch on its socioeconomic, political and historical context. Thus, the originality of this thesis lies in its critical appraisal gaze of a biomedical technology that has been running in the UK for more than 10 years, absorbing more than 10 billion pounds public expenditure (Raleigh & Klazinga, 2013), since its introduction in 2004. Despite what was published on the QOF until now, this thesis goes beyond what has been emphasised so far.

Chapter 2 provides a historical perspective of general practice as a branch of medicine distinctive from consultants or focal specialists (i.e. cardiologists, endocrinologists, etc.). Then, through the prism of quality pursuit in general practice, it shows how different contract arrangements have influenced the very practice and definition of general practice. This, in essence, constitutes the genealogy of QOF. The dialectic struggle between GPs and policy-makers provides a rich account where distinct traditions historically met in negotiation tables, representing three important and different contracts. This historicity offers a background against which the QOF scheme, as a biomedical technology, can be dissected into its mechanisms and rules. This presents sufficient knowledge for the reader to understand QOF's intrinsic nature, a fundamental step to better capture its operational aspects.

Chapter 3 describes the ethnographic study carried out in two different general practice medical groups that provided an adequate space for studying QOF as a biomedical technology. The struggle to get research access to the GP surgeries opened a third satellite research space: a GP training programme. This space offered a reflective, informative and acculturation process into the UK GPs' working and training environment. These three spaces allowed for a multi-sited ethnographic fieldwork, expanding the understanding on general practice and, therefore, providing a rich account of the QOF scheme.

Chapter 4 problematises the QOF scheme through Foucault's perspective on governmentality. It offers a thick description and documentation of an important aspect of this biomedical technology as a surveillance mechanism that affects both health workers and patients alike. It shows the importance of IT system and software packages in expanding government disciplinary techniques over individuals' lives.

Chapter 5 takes further Foucault's concept, as Nikolas Rose did, by connecting biopower to the circuit of today's bioeconomy, which treats health as a lucrative enterprise. In other

words, it documents the commodification process coming from within the NHS internal-market that prevents 'laypeople' from seeing how QOF has pushed further the process of privatising the NHS.

Chapters 6 and 7 depict QOF as a 'big game' where practice teams have to 'dance and play' according to its rules. Being a top-down policy for controlling what counts as good practice, as well as a way of funding general practice, it pressurises the working environment as practices reach the end of the financial year. This tends to distort the personnel behaviour, producing a spectrum of approaches to QOF targets, ranging from simply playing according to QOF rules (Chapter 6) to gamesmanship with regards to them (Chapter 7). This might have consequences for data quality production and variation in the care being delivered.

Chapter 8 takes QOF depression indicators as a case study to illustrate how the discourse of evidence-based medicine has changed the indicators criteria and points allocation over 10-year period. The powerful macro-level around QOF policies is constructed in accordance with: (a) secondary data (government agencies documents); (b) major scientific literature on QOF depression indicators; (c) the debate between GPs and researchers; and (d) the influence of pharmaceutical industry in supporting researchers who were involved in building the QOF depression indicators. After presenting this background, the chapter discusses the meso-level (institutional) and micro-level of general practice agency in dealing with QOF artificiality, opening the scope of data production in order to secure practice incomes and quality standards.

Chapter 9 provides a reflective summary of the themes discussed and frames QOF as a biomanagerial *dispositif* that might have important consequences for UK general practice. In this regard, this thesis wants to make a unique contribution to the field of anthropology of health and well-being, by shedding light on the effects of biomedical technology in general practice.

Chapter Two

THE GENEALOGY OF QOF: DEFINING QUALITY IN GENERAL PRACTICE

This chapter presents the genealogy of the Quality and Outcomes Framework (QOF). It is based on both the academic literature and secondary data sources such as QOF contracts, government policies, and data on QOF achievement levels from the Health and Social Care Information Centre (HSCIC). Firstly, it starts with a brief history of general practice, its origins, and the milestone characteristics that define this field of medicine as culturally different from its counterparts in other branches of medicine. These cultural aspects are relevant when studying any health related issue by placing it within a system of meaning, as well as its political and economic constraints (Bibeau, 1988). Secondly, it discusses the main contract agreement between government and general practitioners to elucidate the influence of economic and political factors in shaping GPs' cultural identity. Thirdly, it introduces QOF in a comparative fashion, tracking its 10-year transformation period, illustrating the main changes in each QOF domain. Finally, it presents QOF's mechanisms such as point values, rules and the importance of IT systems that in theory, at least, enable the realisation of policy-makers' ambitions of improving health standards through QOF.

GENERAL PRACTICE*:* ESTABLISHING A DIFFERENT CLINICAL IDENTITY

The origin of general practitioners in the UK is thought to come from a blend of apothecaries and surgeons in the nineteenth century. In 1840 general practice was firmly established: 'There were a substantial number of medical men, joined by a sense of corporate identity, who adopted and wished to be known by the title of "general practitioner"' (Loudon, 1983, p. 13). The model of medicine provided by general practitioners has been designated as Bedside Medicine in part characterised by a home-visiting or home-calling style of practice (Loudon, 1984). In this model, the private arrangement, either by individual patients or by a collective of workers, produced a form of patronage where patients were more in control of the care and of their environment. As Armstrong explains (1979, p. 2), 'the effect of this continuation of a form of patronage ensured that elements of the earlier cosmology of Bedside Medicine persisted within general practice'. This was to be contrasted with an emerging hospital-based medicine at the end of nineteenth century and beginning of twentieth century.

In 1910, the Flexner Report was utilised to standardise medicine in United States, which became firmly based on the 'scientific' model of German medicine: in the 'German model of medical education […] students spent their first two years in the basic laboratory sciences before progressing to their clinical training on wards in a university hospital' (Duffy, 2011, p. 271). Consequently, in the US 'by the 1930s, the standardisation of the laboratory and hospital-based research medical university model that Flexner advocated in his report have been accomplished' (Beck, 2004, p. 2140). Thus, if the 1800s became the age of general practice, the 1900s marked the age of increasing specialisation in medicine (McWhinney & Freeman, 2009). In the US at the beginning of the twentieth century family medicine, or general practice, has almost vanished, with middle class people being seen directly by specialists or consultants (Loudon, 1984).

The scientific-laboratory hospital model of 'producing' doctors in high-income countries prevailed throughout the twentieth century. This model was coined as the biomedical model, which tends to have a narrow vision of human beings. The biomedical model commonly frame humans in terms of their bodily parts, fostering body-mind dualism and fragmenting care by decontextualising the disease/illness phenomenon from its socioeconomic environment (Checkland et al., 2008). Contrary to what happened in the US, in the UK various factors have contributed to general practice survival. For instance, the middle class in Britain regarded the lab-hospital model with suspicion, preferring the 'old safer world of domiciliary whole-person medicine' (Loudon, 1984, p. 358). In the UK general practice, with a patronage context, patients remained more in control, whereas in hospital-led medicine this control was handed over to doctors (Armstrong, 1979).

Moreover, after the WWII, the biomedical model of practicing medicine gradually started to be questioned by 'social scientists, feminists and others who saw it as political in the sense of diverting attention from the social and economic causes of disease' (Checkland et al., 2008, p. 790). In the UK, the National Health Service has had a fundamental role in strengthening general practice since GPs have become the gatekeepers for patients to access secondary and tertiary care levels within a hierarchical health system (Franks, Clancy, & Nutting, 1992). Hence, from 1950s to 1960s there was an effort to improve the standards of general practice and influence both undergraduate and post-graduate training courses in countries such as 'Britain, Canada, the Netherlands, and the United States' (McWhinney & Freeman, 2009, p. 7).

In 1952, the inception of the College of General Practitioners (later Royal College of General Practitioners - RCGP) aimed to create a distinct academic identity for general practitioners: 'something other than an attenuated version of hospital specialisms' (Checkland et al., 2008, p. 790). For instance, GPs core values have been gradually forged: starting in the late 1950s with Balint's biographical model of clinical care (Lakasing, 2005), endorsed by Engel's (1977) biopsychosocial model of practice, and reaching the 1990s with McWhinney's (1996) construct of 'organismic thinking', to transcend the biomedical model in clinical practice, by making it subservient to human beings. The organismic thinking refers to human intrinsic 'healing powers' such as 'growth, regeneration, healing, learning, self-organisation and self-transcendence' (McWhinney, 1996, p. 434).

Taking into account the importance of patient-centred and communication skills in general practice, clinically applied anthropology played a role in helping doctors become more 'culturally competent' and therefore improving patients' adherence to doctors' recommendations. For instance, doctor-patient encounters usually entail a negotiation of different explanatory models (EMs), and problems may result from an ineffective negotiation process of these different EMs (Kleinman, 1978).

However, helping doctors to be 'culturally sensitive' has been viewed with suspicion by critical medical anthropologists: '"cultural sensitivity" is today the mark of the well-educated and sophisticated biomedical practitioner, just as dabbling in ethnology was once the mark of the sophisticated colonial administrator in the tropics' (Scheper-Hughes, 1990, p. 191). Thus, anthropologists have given their input in framing the doctor-patient encounter and the role of culture in influencing health results (Helman, 2007). This epic debate has been summarised by Lock and Nguyen (2010, p. 8) as the 'medicalization of culture', a process whereby western health professionals in high-income countries are being trained in "cultural competence" or to develop an "ethnically sensitive health care" practice. Currently, cultural competence should be understood as 'caring competence', which encompasses both patients' diversity and professionals' self-acknowledgement of their own systems of value (Napier et al., 2014).

A culturally distinct branch of medicine

In the Lancet report on Culture and Health, Napier et al. (2014, p. 1610) define culture as 'shared, overt and covert understandings that constitute conventions and practices, and the ideas, symbols, and concrete artefacts that sustain conventions and practices, and make them

meaningful'. Applying this definition, we could consider how GPs have developed a distinct cultural identity throughout the twentieth century by defining their core values as based on conventions and practices of the doctor-patient relationship. This does not mean that GPs core values based on holism and community-patient centeredness have been homogeneously distributed. To state that GPs share socially agreed understanding expressed through practice, artefacts and symbols does not deny the presence of dialectic relations, since their members have not 'always subscribed to' what is conventionally shared or is 'overtly understood from within'. (Napier et al., 2014, p. 1609).

Broadly speaking, GPs have evolved and conceptualised themselves as a unique 'clinical reality' based on a doctor-patient relationship which has a different approach to health and illness, compared to consultants and hospital-based medicine. These hospital doctors were firmly based on a biomedical model, defining themselves in terms of human organs (i.e. cardiology, endocrinology, etc.) or technologies (radiology), which tends to isolate the disease from the individuals and their contextual lives (McWhinney, 1996). The coexistence of different medical models, bedside medicine, and hospital-based medicine is in line with Arthur Kleinman's construct of a health system as a cultural system. For Kleinman, the health system encompasses different clinical realities (professional, folk and popular), as well as allows for, within the same professional sector, different systems of values and explanatory models of health and illness (Kleinman, 1978).

In order to contribute further to the debate of the evolving nature of general practice, a perspective on the monetary and political forces needs to be included. This gives support to epistemological transformations in medicine in general, and in general practice, in particular. By adopting a Gramscian approach to culture understood as historical 'dialectical process comprising power and knowledge' (Pizza, 2012, p. 98), an account can be built where multiple forces have dynamically operated to form the current general practice's conventions and practices, i.e. culture. This contextual transformation produced a clinical governance framework, which was epitomised by the 2004 General Medical Service (GMS) contract.

GENERAL MEDICAL SERVICE CONTRACTS: SHAPING GENERAL PRACTICE IN THE UK

In the UK, general practitioners have historically held the status of independent contractors. This was established prior to the NHS through the Health Insurance Act of 1911, which was

the first government initiative to officially organise medical service provisions in the country. In this arrangement, GPs were paid through a capitation system (Pereira Gray, 1977). This independent contractor status remained a pivotal 'freedom to practice' issue for GPs, and its maintenance was essential for their agreement to support the creation of the NHS. Their stance led to a 'deal struck between the British Medical Association (BMA) and the post-war Labour government under which GPs should not become salaried employees of the state' (Addicott & Ham, 2014, p. 7).

Thus, since the inception of the National Health Service in 1948, most GPs have been 'self-employed', which means that the NHS does not employ them directly (Gregory, 2009). By managing to be contracted *for* service and not hold to a contract *of* service, GPs remained outside of a more hierarchical and bureaucratised structure, compared to hospital doctors (Pereira Gray, 1977). One of the natural consequences of this 'independent contractor arrangement' is the variability in standard of general practice services *(ibid.)*. This would have implications for government's aspirational quality standards in general practice in the subsequent years.

Additionally, the rise of the NHS produced a mutual dependence context: the state became a 'monopoly' employer and health resources provider, but simultaneously reliant on the medical profession both to run the NHS and to ration its limited resources. This situation was framed as the 'politics of the double bed: peace between partners through propinquity' (Klein, 1990, p. 702). This environment of mutually dependent political kinship, where different powerful members exert their interests, is formalised through the medical services (MS) contract negotiation process. Currently, contracts can be roughly divided into either a general medical contract (GMS) or a personal medical contract (PMS). Both are fairly similar, the latter allowing for more flexibility on locally agreed enhanced services (Gregory, 2009).

Since the foundation of the NHS, general practitioners, through their representatives, have nationally negotiated a medical service contract with government. Historically, three contract negotiations are relevant to the present discussion: 1966, 1990 and 2004 contracts. The latter harbours the Quality and Outcomes Framework scheme, the focus of this research.

1966: quality as a professional duty

The GPs' independent contractor status, as previously mentioned, inevitably fostered a range of standards in health care services. Two years after the foundation of NHS, Collings' report described general practice as a 'dirty and ill-equipped' space with 'rusty and dusty antique instruments', and regarded its overall quality as 'bad' and 'deteriorating' (Kmietowicz, 2006, p. 39). In this context, most GPs were working under pressure, isolated from other professional colleagues – as 'single-handed practices or with one partner' - with limited support (Goodwin, Dixon, Poole, & Raleigh, 2011, p. 13). An effort to improve the situation of general practice in the UK can be traced back to the General Practice Charter in 1965 (accepted in 1966).

By becoming a key element of the health system, GPs managed to obtain a new contract with the government. This increased their overall remuneration, as well as reduced their patients' list size to a maximum of 2000 patients (Goodwin et al., 2011). Four principles comprised the 1966 contract: (1) the right to practise good medicine in up-to-date, well-staffed premises; (2) the right to practise medicine with the minimal intrusion by the state; (3) the right to appropriate payment for services rendered (which is still in place today); and (4) the right to financial security (Lewis, 1998). The 1966 contract has been regarded as a turning point in UK general practice leading to a teamwork environment, improvement in GP premises, and increasing GPs' financial security by adding the 'basic practice allowance' (a sort of salary component). Through the 1966 contract, GPs' autonomy was strengthened by the government, which increased GPs' morale (*ibid.*) and paved the way for what has been called the "golden age" of general practice (Addicott & Ham, 2014).

Despite both parties recognising the need to improve quality standards in general practice, there was no consensus on what constituted a good general practice at that time. For instance, 'the 1960 Royal Commission and the Pay Review Body wanted to introduce merit awards for GPs' and even, there was a determination to 'draft a scheme', in 1965, by the RCGP (Lewis, 1998, p. 138). However, due to lack of agreement around quality standards, the government had no option, but to trust in the profession to set quality standards in general practice. This can be summarised by Shields' statement (1965, p. 52): 'We want to be trusted individually and as a profession, and we want to play the game without a surfeit of regulations, orders, and officials'.

1990: quality as an 'accountancy' model

The result of the mid-1960s contract helped to improve general practice and by the 1980s, most preventive activities such as cervical smears, immunisation, family planning, as well as chronic and acute care, were being delivered within it. Furthermore, the health care team had increased with practice nurses, community nurses and health visitors working together and expanding the services it offered (Pereira Gray, Marinker, & Maynard, 1986). Nevertheless, certain problems still remained such as immunisation coverage rates and quality in patients' record information. Some patients faced difficulties registering with a practice and there was variability in hospital referral rates from 2% to 24% *(ibid.)*. This context raised the concern of both government and professionals about the quality of general practice.

Despite quality standards in general practice being at the centre of the discussion in the 1980s, there was still a lack of consensus around their definition, which weakened GPs' relation with the government (Lewis, 1998). This is mirrored by the NHS Act 1977 that described the scope of general practice as 'to render to their patients all necessary and appropriate personal medical services of the type usually provided by general practitioners' (Pereira Gray et al., 1986, p. 1314). This vagueness in general practice quality standards started to be challenged by a new style of running the public sector, marked by the policies of Margaret Thatcher's conservative government. This has been coined as new public management (Lewis, 1998). The new approach to the public sector favoured a more private, business style of management with an increased focus on accountability, results, performance, and outcomes. Additionally, an emphasis on management of people, resources, and programmes was implemented. Pollitt (1993, p. 11) has called this approach into the public administration as 'welfarism': the 'injection of an ideological foreign body' (managerialism) into the welfare state. In a new political scenario, general practice was being compelled to change in order to become publicly accountable.

As Pereira Gray et al. (1986, p. 1314) stated, the 'absence of any substantial accountability, makes it difficult to convince government or colleagues in the hospital services that expenditure on primary health care represents value for money'. These authors were in support of government proposal for a 'good practice allowance', arguing that some aspects of general practice could be measured against standards, such as 'clinical performance, anticipatory care, and the organisation of the practice' (Marinker, Pereira Gray,

& Maynard, 1986, p. 1374). The debate around the government's prospect of a new contract was heavily criticised by the British Medical Journal (BMJ):

> The wish for cost effectiveness through greater (possibly privatised) competitiveness may have launched the government on its quest to improve primary care, but a quest for quality has joined *value for money* [emphasis added]. With a combination of financial incentives, consumer choice, and tougher supervision by family practitioner committees the government wants "to raise the general quality of these services nearer to that of the best". (BMJ, 1986, p. 1159)

In the above quotation, the BMJ is criticising government's 'new managerial style' where quality was being equated to 'value for money'[1]. However, value for money entails maximum efficiency-effectiveness and minimum purchase price ratio (BusinessDictionary.com). It focuses more on what works, time consumed and money spent, which does not necessarily relate to a quality dimension.

The BMJ quotation also reflects the general practitioners' morale. Compared with the 1966 and 2004 context where GPs' recruitment and morale were low (Addicott & Ham, 2014; Roland, 2011), general practice in the 1980s was a very attractive career showing a steady increase in recruitment of new doctors. Women doctors constituted 'nearly a third of those under 35 compared with 9% of those aged 65 or over' (Iliffe, 1996, p. 201). Additionally, with the number of GPs going up, the doctor/patient list ratio went down and, consequently, the time doctors spent with their patients increased *(ibid.)*. Therefore, in the 1990s' contract, the main proponent for a new agreement with GPs was the government who wanted to 'impose a contract on NHS general practitioners' (BMJ, 1989, p. 414). This might be a reflection of Whitehall's new 'vocabulary', which has incorporated the 'virtuous three Es: economy, efficiency and effectiveness' (Pollitt, 1993, p. 59). This new style of running the public sector was embedded in a bigger change: the introduction of an artificial internal market.

According to Gramsci, the 'Free Trade' movement, based on the ideological distinction of civil and political society is a myth that disguises the state economic regulatory role. He states that:

[1]In Britain, this expression 'value for money' is used in many situations such as shopping, restaurants, hotels and so on, which for foreigners might sound odd as it does not express quality as in the case of a meal or an

> Since *in actual reality civil society and State are one and the same*, it must be made clear that *laissez-faire* too is a form of State 'regulation', introduced and maintained by legislative and coercive means. It is a deliberate policy, conscious of its own ends, and not the spontaneous, automatic expression of economic facts. (SPN: 159-60, cit. in Crehan, 2002, p. 104)

In 1991, the Conservative white paper *Working for Patients* (Secretaries of State for Health 1989) introduced a 'purchaser/provider split' arrangement. This led to a considerable transformation in the public health sector (Harrison & Wood, 1999). The internal artificial market organisation meant a radical shift within the NHS itself: a move from a monolithic structure to a web of interconnected parts with specific roles and agency given to each component part. This was central for creating an internal competitive structure or quasi-market within the public sector, as stated by Laing, Cotton, Joshi, Marnoch, and McKee (1998, p. 22):

> Following the reforms this unitary structure was fragmented into those organisations responsible for the actual delivery of services, the providers, specifically self-governing NHS hospital trusts; and those responsible for buying or commissioning health care on behalf of the population they represented, the purchasers, namely health authorities and, more importantly, GP fundholders.

The artificial internal market arrangement meant that instead of giving money directly to providers such as hospitals and community services, the government wanted to stimulate competition by breaking up a mega-structure into multiple providers (e.g. hospital trusts). Then, commissioners (health authorities and GP fundholders) could buy health services they needed among competing providers. The hope was that this artificial internal market would reduce costs, improve quality and promote innovation, i.e. that market forces would drive the NHS's quality and cost-effectiveness. Today the government transfers money to clinical commissioning groups (CCGs) to buy the health care services on behalf of their population, whereas in the past it was the health authorities, GP fundholders' arrangement and, then, primary care thrusts (PCTs) that did this.

In the NHS artificial internal market, GP fundholders induced great transformation in general practice. Despite its volunteer nature and initial resistance, by 1996 60% of GPs had become fundholders (Harrison & Wood, 1999, p. 758). This meant that GPs were responsible for both the management of their own premises and for purchasing other health services (secondary care) either from the public or the private sector (Laing et al., 1998). The use of

public funds within this internal market meant a range of new reporting requirements and managerial activities, e.g. the establishment of '"business planning" budgetary control structures within general practice' (Laing, Marnoch, McKee, Joshi, & Reid, 1997, p. 83). Consequently, this structure of an internal market demanded greater regulatory processes and accountability in general practice. The new framework tried to stimulate GPs into being entrepreneurs, since they were small business holding an independent contract status.

However, the main reason for GPs to be self-employed was to secure their autonomy with most GPs behaving as salaried doctors, not as businessmen. General practitioners always tried to secure the benefits of being a formal employee without the need to move into a salaried contract (Lewis, 1998). To challenge GPs' comfort zone, the 1990 contract reduced the 'basic practice allowance' and increased the capitation in order to create more uncertainty and competition. This meant an increase in 'capitation payments from 45% (the result of introducing various salary and item-of-service payments in the I960s) to 60% (Day, 1992, p. 168). At the core of this new market-driven public sector was the ideal that competition would drive quality.

In the development of the 1990 contract, government encountered both GPs with a high self-esteem and difficulty in pinning down quality standards for general practice. For instance, the General Medical Service Committee (GMSC), in 1984, proposed that GPs' formal 'training secured quality and that accountability could only be "personal to the patient" (Lewis, 1998, p. 138). Similarly, the BMJ stated that:

> [It was] one thing to have clinical advice issued as guidance, but to be told when to measure blood pressure, test a urine sample, or ask for a family history in the regulations of an act of parliament is another dimension altogether. (BMJ, 1989, p. 414)

This tension around the quality standards and greater accountability produced a contract comprising four interconnected issues (Lewis, 1998): (1) an intensification of competition amongst doctors, by increasing the capitation payment and proportionately reducing the basic practice allowance; (2) greater specification of the terms of services delivered, which increased the fee-for-service payment modality. These were built around health promotion activities such as health checks on new patients, regular checks on the over-75s or on patient aged 16 to 74 years old who have not seen a GP within the previous three years, and the provision of advice on smoking cessation; (3) increase in accountability; and (4) greater

quality assurance with the creation of Family Health Services Authorities, as exemplified by prescribing cost control through the use of 'indicative drug budgets' (Addicott & Ham, 2014, p. 9).

Hence, the 1990 GMS contract formally challenged doctors' autonomy and strengthened the management of general practice by introducing audit as a requirement, resulting in significant 'change in the attitudes and practice of GPs' (Roland, 2011, p. 9). If in the 1960s' GPs succeeded in retaining their status as 'independent contractors' in the 1990s' the state insisted on a greater accountability (Lewis, 1998).

2004: quality as a bureaucratic model

The 2004 contract should be understood as the realisation of the 1990s' contract ideal, as had been envisaged by Pereira Gray et al. (1986, p. 1315):

> It can be expected that contractual negotiations in the mid-1980s will be about process and so focus on quality of performance in general practice. Experience so far suggests a 20-year cycle in the negotiation of contracts. Perhaps the negotiations around the year 2006 will be about outcome.

The QOF scheme, though introduced in 2004, suffered a major change in 2006 expanding its clinical targets in order to improve quality via pre-established clinical outcomes. Hence, the questions that follow are: what changes made possible the incorporation of the Quality and Outcomes Framework into the 2004 contract? How and why had GPs, as a professional body, changed to accept when ''to be told to measure blood pressure, test a urine sample, or ask for a family history" (BMJ, 1989, p. 414)? The introduction of a more market-driven public sector environment and its new management style in part explains these questions. Nevertheless, without an important epistemological change in medicine it would be much harder for the government to implement QOF. As Foucault (2003, p. 39) argues, to legitimise government's rights and its disciplinary apparatus 'there is a greater and greater need for a sort of arbitrating discourse, for a sort of power and knowledge that has been rendered neutral because its scientificity has become sacred'. In the internal market arrangement, different rationing criteria for health services and technologies were needed. The purchaser-provider split had created a demand for a new actor in the decision-making process for dealing with the pressure from consumers' and suppliers' demands for health services and technologies. In this regard, Evidence-Based Medicine plays a fundamental role (Harrison, 1998).

EBM: a 'new' paradigm

From the 1990s onwards, EBM gradually became a model for both teaching and the practice of medicine, as well as a standardised model for helping decision-makers determine whether or not a new technology should be adopted by a health provider (Lambert, Gordon, & Bogdan-Lovis, 2006; Sackett, Rosenberg, Muir Gray, Haynes, & Richardson, 1996). For instance, in 1979 the Canadian Task Force (CTF) on Periodic Health Examination and, in the mid-1980s, the US Preventive Service Task Force (USPSTF) systematically started to evaluate and rank both the medical evidence available and the strength of recommendation for adopting a health intervention or not (Harrison, Moran, & Wood, 2002). In the UK, the new (post-1997) Labour Government launched a similar institutional approach for assessing health technologies (i.e. medical treatments) and for securing 'professional compliance'. Therefore, in 1999, the National Institute for Health and Care Excellence (NICE) was created "to give a strong lead on clinical and cost-effectiveness" (Harrison et al., 2002, p. 12). NICE was to 'undertake 30 to 50 evidence-based appraisals per annum of new or existing clinical interventions' *(ibid.)*.

Two main characteristics of EBM can be highlighted: one is the standard criterion for evaluating effectiveness of an intervention; the other is the production of clinical guidelines to communicate its research findings. The former helps policy-makers circumvent difficult rationing decisions by providing a 'neutral' scientific and common sense rationing tool; the latter deals with the doctors' autonomy and the 'problem' in care variability.

Evidence-based medicine has the hegemonic power to establish what counts as a cost-effective health care intervention. By evaluating and ranking the evidence it produces a hierarchical judgment that places randomised controlled trials or their meta-analysis at the top and professional experience at the bottom. An example of such a classificatory model can be seen in the NICE's clinical guideline Nº 31 for obsessive-compulsive disorder. NICE's hierarchical grade of recommendation (Figure 2.1) was adapted from the US Agency for Healthcare Policy and Research Classification (NICE, 2005, p. 43).

The EBM hierarchical classificatory approach to medical knowledge has diminished the authority of practicing clinicians and increased the power of those physician researchers, epidemiologists or academics that mastered the nuances of the 'new' paradigm (Lambert et al., 2006; Harrison et al., 2002). In this context of medical knowledge, EBM has then become

'the unitary theoretical instance that claims to be able to filter them, organise them into a hierarchy, organise them in the name of a true body of knowledge, in the name of the rights of a science that is in the hands of the few' (Foucault, 2003, p. 9).

Level	Type of evidence	Grade	Evidence
I	Evidence obtained from a single randomised controlled trial or a meta-analysis of randomised controlled trials	A	At least one randomised controlled trial as part of a body of literature of overall good quality and consistency addressing the specific recommendation (evidence level I) without extrapolation
IIa	Evidence obtained from at least one well-designed controlled study without randomisation	B	Well-conducted clinical studies but no randomised clinical trials on the topic of recommendation (evidence levels II or III); or extrapolated from level I evidence
IIb	Evidence obtained from at least one other well-designed quasi-experimental study		
III	Evidence obtained from well-designed non-experimental descriptive studies, such as comparative studies, correlation studies and case studies		
IV	Evidence obtained from expert committee reports or opinions and/or clinical experiences of respected authorities	C	Expert committee reports or opinions and/or clinical experiences of respected authorities (evidence level IV) or extrapolated from level I or II evidence. This grading indicates that directly applicable clinical studies of good quality are absent or not readily available
		GPP	Recommended good practice based on the clinical experience of the GDG.
Adapted from Eccles M, Mason J (2001) How to develop cost-conscious guidelines. *Health Technology Assessment* 5:16 and Mann T (1996) *Clinical Guidelines: Using Clinical Guidelines to Improve Patient Care Within the NHS*. London: Department of Health.			

Figure 2.1. NICE 2005 grading scheme. Source: NICE, 2005, p. 43.

If in the past quality in general practice has been difficult to establish, the rise of EBM has been a watershed. Consequently, those things that were not measurable and framed in accordance to an EBM paradigm were downgraded. For instance, other medical rationalities like acupuncture and homoeopathy, which have different approaches to illness, have been regarded as less scientific (Barry, 2006). To some extent, the more subjective aspects of

general practice, such as holism and patient-centeredness, suffered the same consequences, as they are difficult to measure or to put in a template. Both complementary alternative medicine (CAM) and the holistic approach in general practice have gradually become what Foucault (2003, p. 7) calls "subjugated knowledges", those 'knowledges that have been disqualified as non-conceptual knowledges, as insufficiently elaborated knowledges: naive knowledges, hierarchically inferior knowledges, knowledges *that are below the required level of erudition or scientificity*' [emphasis added].

The EBM, with its population-based approach has increased the level of abstraction in medical healthcare (Goldenberg, 2006), moving away from an individual-based personal type of healthcare, common in general practice. This context has produced a peculiar type of metric healthcare (Loxterkamp, 2013) backed by a 'scientific-bureaucratic' model of practicing medicine:

> [It is] scientific' in the sense that it draws on the accumulated evidence of large-scale research, and 'bureaucratic' in the sense that it translates the output of such research into a particular species of bureaucratic rule, the 'clinical guideline', for application in medical care organisations. (Harrison et al., 2002, p. 3)

The scientific-bureaucratic model of practice medicine was perfect for New Labour's apparatus for controlling doctors and other healthcare professionals. It was called clinical governance:

> That action will be guided by a single, robust framework – a new system of clinical governance – to monitor health care quality at a local level. This will be backed up by lifelong learning by staff, through rigorous professional self-regulation and through a new system of external monitoring. (NHS Executive, 1998, p. 33)

The National Institute for Health and Care Excellence (NICE), the National Service Frameworks (NSFs) and the Commission for Health Improvement (CHI) were part and parcel of this apparatus of 'clinical governance' (Harrison et al., 2002). Hence, throughout the 1990s physicians were acculturated into the ideal of a 'gold standard' way of practicing medicine, showing that 'bad' and 'good' medical practices occurred, that some aspects of quality of care could be measured, and that there were 'justifiable limits to individual freedom in the clinical setting' (Roland, 2004, p. 1449).

The clinical governance environment in which GPs were working facilitated the negotiation process for the 2004 contract. This new contract was in line with Whitehall's slogan: 'What counts is what works' (Harrison, 2002); or in the prophetic words of Pereira Gray et al. (1986, p. 1315) the new contract needed to be 'about outcome'. Having identified these socioeconomic, political, and cultural changes in the general practice landscape, the next topic considers a crucial point for the arrival of QOF: the 2004 contract itself.

The 2004 contract deal: a piece of cake

The 2004 contract was part of the NHS modernisation plan to further improve quality standards in primary care. In regard to GPs' payment, the contract allocated GPs' earnings into three payment tiers: (1) a global sum (based on capitation or practice list of registered patients); (2) a sum for an enhanced service (whereby practices could opt to offer additional services such as extended opening hours, minor surgeries, and so on); and (3) the Quality and Outcomes Framework (Addicott & Ham, 2014). Other important elements were embedded in the 2004 contract: the regularisation of salaried GPs' situation; the establishment of contract between the GP practices and the department of health rather than with individual GPs; the sponsorship of general practices' IT system improvement; and the possibility for GPs to renounce their out-of-hours care duty (Peckham, 2007). The latter deserves a closer look, as it meant important economic gains and workload reduction for GPs.

The new contract allowed GPs to opt out their out-of-hours duties as long as they were willing to lose £6000 year. However, GPs were already paying an average of £13000 year for a deputising service (National Audit Office, 2008, p. 19). Thus, the majority of GPs gave up their 24/7 commitments and got an average pay rise of £7000 year. The significance of out-of-hours goes beyond monetary gains, because it has close links with GPs' practice workload and the prospect of having a normal Monday to Friday working week. Additionally, as in the 1966 'basic practice allowance', the BMA secured a Minimum Practice Income Guarantee (MPIG) before the contract was agreed as 'transitory protection of their income while the new contracts were embedded' (National Audit Office, 2008, p. 15).

On top of all these elements, there was the QOF, a point-based pay-for-performance (P4P) scheme, which had the prospect of further increasing GPs' earnings. Even the BMA had warned the Department of Health representatives that the quality standards would be

easily achieved by GPs (National Audit Office, 2008). The unfolding events would prove the BMA was right. For instance, policy-makers had anticipated that GPs would achieve around 750 points of the available 1050 QOF points, but in fact, in the first year GPs managed to get 959 (91%) of the available QOF points. This meant that the government had to find 'extra £200m to cover the difference' (Cole, 2005, p. 536). As a result, the average payment of GP partners increased by 58% in the first three years of the new contract (National Audit Office, 2008, p. 19).

Another important issue documented by the BMA 2001 survey showed that nearly 60% of GPs rated their morale as 'low' or 'very low' and 25% 'were considering leaving general practice' (National Audit Office, 2008, p. 14). Thus, at that point of negotiating the new contract, GPs' income, morale and recruitment were low (Roland, 2011). Therefore, the conditions made it very appealing to GPs, and in June 2003, 79% of general practitioners voted in favour of the new contract to start in April 2004 (Roland, 2004).

However, to state that QOF is a voluntary scheme is to deny the powerful imbalance built into the 2004 contract, which made it almost impossible for GPs to refuse the new 'quality' framework embedded within it. Moreover, its voluntary nature was politically wise, since it conveyed the sense of a horizontal rather than a top down agreement. This type of strategy diffuses the opposition, and offers time to those unsure about the changes to accommodate to the new policy (Harrison & Wood, 1999). To some extent, the 2004 contract represents a state 'domination' tactic through its coercive monetary arrangement and consent, as it comprises the 'intellectual morality' of EBM quality and best practice discourse, and therefore 'creating an "ethical-political" relationship with the people' (Gramsci, 1971: 207, cit. in Kurtz, 1996, p. 104).

In summary, during the twentieth century general practice in the UK transformed itself according to socioeconomic and political forces depicted by three main contract agreements: 1966, 1990 and 2004. It went from a pluralistic, almost chaotic, unrecognised branch of medicine (before the NHS) to the cultural distinctiveness displayed after the 1966 contract, often depicted as the golden age of general practice (Laing et al., 1997). However, after the 1990s' contract, doctors' autonomy started to be challenged to the point that at the commencement of the twenty-first century the 2004 contract had incentivised a 'scientific-

bureaucratic' model for securing quality in the UK general practice. Thus, I shall now go on to dissect the Quality and Outcomes Framework scheme in more detail.

QUALITY AND OUTCOMES FRAMEWORK: A 10-YEAR 'NATURAL' EXPERIMENT

The Quality and Outcomes Framework is a pay-for-performance scheme implemented in the NHS in April 2004 in order to improve quality of care in the UK general practice. It is considered 'the boldest such proposal attempted anywhere in the world' (Roland, 2004, p. 1448). Usually, the government presents it as a quality practice rewarding scheme rather than a payment modality and its voluntary nature is always emphasised, as stated in the health and social care information centre:

> The objective of the QOF is to improve the quality of care patients are given by rewarding practices for the quality of care they provide to their patients. Participation by practices in the QOF is *voluntary* [emphasis added], though participation rates are very high. (HSCIC, 2010, p. 4)

This statement can be traced back to Margaret Thatcher's new public management style based on measurements, performance and outcomes. Pollitt (1993) has labelled this managerial style as new-Taylorism after Frederick Winslow Taylor's *The Principles of Scientific Management* (1911). Taylor's time and motion doctrine can be characterised by: (1) division of intellectual work (planning and management) and physical work (practical), reminiscent of the biomedical model mind/body dualism; (2) establishing and setting effort levels; and (3) strengthening the control apparatus over the working processes (Pollitt, 1993). The concept behind Taylor's scientific management is very relevant to the present discussion because:

> It proceeded on the basis that previously unmeasured aspects of the work process could and should be measured, by management, and then used as the basis for controlling and rewarding effort. In the 1880s and 1890s it was Carl Barth's slide rule for calculating machine speeds. This is not so far, in principal, from the recent epidemic of electronically-mediated public–services systems of performance indicators, individual performance reviews and merit pay. This slide rule has been replaced by the microcomputer. (Pollitt, 1993, pp. 15-16)

By highlighting QOF's main purpose (improve quality in general practice by paying GPs according to a set of pre-established standard criteria) and resemblance to Taylor's scientific

management and ideological content, what follows presents QOF's main characteristics and modifications.

QOF four domains

Despite QOF changing nature, its four domains (clinical, organisational, patient experience, and additional services) have been relatively stable throughout the 10-year period, with modifications in these domains occurring in the 2013/14 GMS contract onwards.

Clinical

In 2004, clinical domain started with 11 areas (diseases) comprising 76 indicators (HSCIC, 2005). However, in 2006 the clinical domain suffered a dramatic increase in the number of target diseases, expanding to 19 areas encompassing 80 indicators (HSCIC, 2007). Then, the clinical domain suffered small fluctuations, peaking in 2012/13, comprising of 22 clinical areas and 96 indicators (HSCIC, 2013). In 2013/14, the clinical domain subsided to 20 areas (diseases) organised into 93 indicators (HSCIC, 2014b). Throughout this decade, the clinical domain represented the majority of QOF points. For instance, in 2004, the clinical domain comprised 550 points of the total available 1050 points (52.4%), whereas in 2013/14 it represented 610 points of the available total 900 points (67.8%) (HSCIC, 2005; HSCIC, 2014b). Table 2.1 summarises the target disease areas in accordance to the QOF contract changes for the clinical domain. From an anthropological perspective, the emphasis on clinical domain symbolises the hegemony of the biomedical disease model in framing quality of health care.

Table 2.1. Clinical domains milestone changes from 2004 to 2014.

Clinical Domains	**2004/05**	**2006/07**	**2009/10**	**2012/13**	**2013/14**
Asthma	■	■	■	■	■
Atrial Fibrillation		■	■	■	■
Cancer	■	■	■	■	■
Cardiovascular Disease (primary prevention)*			■	■	
Coronary Heart Disease (secondary prevention)	■	■	■	■	■
Chronic Kidney Disease		■	■	■	■
Chronic Obstructive Pulmonary Disease	■	■	■	■	■
Dementia		■	■	■	■
Depression		■	■	■	■
Diabetes Mellitus	■	■	■	■	■

Epilepsy	■	■	■	■	■
Hypertension	■	■	■	■	■
Hypothyroidism	■	■	■	■	■
Learning Disabilities		■	■	■	■
Left Ventricular Dysfunction	■	■	■	■	■
Mental Health	■	■	■	■	■
Obesity*		■	■	■	
Osteoporosis: secondary prevention of fragility fractures				■	■
Palliative Care		■	■	■	■
Peripheral Arterial Disease				■	■
Rheumatoid Arthritis					■
Smoking*		■	■	■	
Stroke and Transient Ischaemic Attack	■	■	■	■	■
Total areas	11	19	20	22	20
Total indicators	76	80	86	96	93
Total points in this domain (%)	550 (52.4%)	655 (65.5%)	697 (69.7%)	669 (66.9%)	610 (67.8%)
Average points achieved (%)	507.7 (92.3%)	630.7 (96.3%)	668.2 (95.9%)	638 (95.4%)	563.64 (92.4%)

* In 2013/14 these clinical areas were moved to the public health domain. Sources: compiled from HSCIC 2005; HSCIC 2007; HSCIC 2010; HSCIC 2013; and HSCIC 2014b.

Organisational

The organisational domain remained relatively stable until 2012/13 contract, encompassing five areas: Records and Information; Patient Communication or Patient Information; Education and Training; Medicines Management; and Clinical and Practice Management. It started with 184 points (17.5%) in 2004 (HSCIC, 2005), reaching maximum points of 254 (25.4%) in 2012/13 (HSCIC, 2013), to be completely retired in 2013/14 (HSCIC, 2014b). This domain aimed to improve the IT systems, data gathering and internal and external communication in general practice. These were essential for establishing standardised QOF informational and monitoring systems. Moreover, it promoted the replacement of patients' paper-based records by electronic versions in UK general practice.

Patient Experience

This domain started with four indicators in two areas (Patient Survey and Consultation Length) that were worth up to 100 points, 9.5% of the total (HSCIC, 2005). This domain remained almost the same until 2010/11 (BMA and NHS Employers, 2011) with its indicators valued at up to 91.5 points (9.15% of the total). From 2011 onwards, patient

experience domain was reduced and kept at 33 points until 2013/14, requiring patients to have at least ten minutes with their GPs (HSCIC, 2014b).

Another characteristic of QOF, which has close links with this domain, concerns Depth of Quality Measurement (DQM). The DQM comprised of three indicators that rewarded the 'breadth of care': holistic care payment (100 points); a quality practice payment (30 points); and patient access to clinical care - access bonus (50 points) (HSCIC, 2005). The 2006/07 contract absorbed most of these points, leaving just the 'holistic care payment', valuing only 20 points (2.0% of the total), to be finally eliminated from the 2008/09 contract onwards. Despite the ideal of 'holistic care' payment lasted just for four years, during this time 'holistic care' became redefined as a measurement payment based on the level of 'achievement across the clinical domain' (BMA and NHS Employers, 2006, p. 16). This is very distant from the holistic care approach proposed by the Royal College of General Practitioners.

The RCGP defines holistic approach as 'caring for the whole person in the context of the person's values, their family beliefs, their family system, and their culture in the larger community'; and additionally, as 'an emphasis on a more participatory relationship between doctor and patient, and an awareness of the impact of the "health" of the practitioner on the patient' (RCGP, 2010, p. 19). It appears that QOF tried to improve its fragmentary nature by adapting the GPs' holistic care concept, but later on, this seemed increasingly irrelevant.

Additional Services

In 2004, QOF additional services domain represented four areas (Cervical Screening, Child Health Surveillance, Maternity Services and Contraceptive Services) constituting 36 points (3.4% of the total) (HSCIC, 2005). This domain slightly increased during this time period and in 2013/14 it represented 44 points on the overall scheme, though in this same year contract it was renamed as a subdomain of public health (HSCIC, 2014b).

QOF's sixth edition: the 2013/14 contract

The pay-for-performance system in the UK general practice reached its tenth anniversary on April 2014 and despite its dubious success and having cost the NHS an estimated £1 billion a year (Raleigh & Klazinga, 2013) the government has renewed its commitment with this managerial quality assurance scheme.

The sixth version of QOF (introduced in 2013) was organised into four domains: (1) Clinical - with indicators in different clinical areas such as heart failure, hypothyroidism and diabetes; (2) Public Health (PH) - which includes indicators that influence both clinical and public health outcomes, such as smoking and obesity, as well as comprises a PH subdomain for additional services organised into four areas: cervical cancer screening, child health surveillance, maternity services, and contraceptive services; (3) Quality and Productivity - indicators aiming at a more effective use of NHS resources through improvements in the quality of primary health care (PHC) services by rewarding practices for reducing avoidable referrals both for ambulatory and Accident and Emergency (A&E) hospital services; and (4) Patient Experience - an indicator of the duration of patients' consultation, which should last at least 10 minutes (BMA, NHS Employers, & NHS Commissioning Board, 2013). The sixth edition of QOF aimed at further improvements in quality by tightening GPs' point achievements, reducing the amount of points available, eliminating most of the organisational indicators, and introducing 'public health' indicators in order to get more with less (Gillam & Steel, 2013). Table 2.2 shows the whole framework and the number of points allocated in each QOF domain.

Table 2.2. 2013/14 QOF domains and points allocation criteria.

Components of total points score	**Points**	**Way in which points are calculated**
Clinical Indicators	610	Achieving pre-set standards in management of: • Atrial fibrillation • CHD • Heart Failure • Hypertension • Peripheral Arterial Disease • Stroke and TIA • Diabetes Mellitus • Hypothyroidism • Asthma • COPD • Dementia • Depression • Mental Health • Cancer • Chronic Kidney Disease • Epilepsy • Learning Difficulty • Osteoporosis • Rheumatoid Arthritis • Palliative Care
Public Health (PH) domain	113	Achieving pre-set standards in: • Cardiovascular Prevention • Blood Pressure • Obesity • Smoking

PH sub-domains	44	Achieving pre-set standards in: • Cervical Screening • Child Health Surveillance • Maternity Services • Contraceptive Services
Quality and Productivity domain	100	Achieving pre-set standards in: • A set of management arrangements to reduce patients avoidable referral to secondary and A&E services
Patient Domain	33	Consultation length (no less than 10 min)
Total possible	900	
In 2013/14, the average value of 1 QOF point = £156.92. CHD = Coronary Heart Disease; COPD = Chronic Obstructive Pulmonary Disease TIA= Transient Ischemic Attack.		

Source: BMA, NHS Employers, & NHS Commissioning Board, 2013.

QOF points and value

Over a ten year-time period the total of QOF points have remained relatively stable. It started with 1050 points, being reduced in 2006/07 to 1000 points, and reaching 2013/14 at 900 points. However, for the annual 2014/15 QOF has been shrunken to allocate just 559 points across two domains: Clinical Domain (435 points) and Public Health indicators (124 points) (BMA, NHS Employers, & NHS England, 2014). This downward trend in QOF overall points suggests that the government might be manipulating QOF as a mechanism to reduce GPs' economic gains.

Nevertheless, as QOF unitary point value has followed an opposite trend if compared with the overall point scheme, this might suggest the BMA's contractual influence to minimise GPs' economic loss. In 2004/5, each point was worth approximately £75, but experienced an up rise of 60% in 2005/6 with each QOF point having an average value of £120 (Checkland et al., 2008). Then, in the following years it was slightly increased to £124.60 in 2006/07 (Simon, 2008a) reaching in 2011/12 an average value of £130 (Gillam & Steel, 2013). In 2013/14, despite QOF as a whole being reduced to 900 QOF points, each QOF point on average was rated at £156.92. Within these 900 QOF points, patients' experience represented only 33 points and the vast majority of point payments were linked to the clinical indicators and public health (BMA, NHS Employers, & NHS Commissioning Board, 2013).

In regard to general practitioners total income, QOF represents roughly a quarter of their annual revenue (Checkland et al., 2008). In England, most practices receive 70% of their payment in advance (divided in 12 months) based on the QOF points earned in the previous year. This is calculated by the 70% monthly aspiration payment method (NHS England, 2013). For instance, adjusting for 2013/14, the aspiration payment would be based on 2012/13 total QOF points achieved × £159.92/point × 70% × adjustment for list size and composition (formula adapted from Simon, 2008b, p. 137). Then, at the end of financial year on March 31st, the 'aspiration payment' will be deducted from the practice total QOF points' achievement (the 'achievement payment') resulting in the practice 'actual payment' *(ibid.)*. Hence, this advance payment creates a process whereby at the end of financial year practices might be financially penalised if they do not achieve the 70% pre-established level of accomplishment.

Understanding QOF rules

The clinical quality in QOF remains as a points-based system using modified audit mechanisms, since it defines criteria and corresponding standards for each clinical indicator against which quality is measured. Figure 2.2 illustrates QOF 2013/14 hypertension criteria (indicators), corresponding standards (achievement threshold), and the allotted points.

Hypertension (HYP)

Indicator	Points	Achievement thresholds
Records		
HYP001. The contractor establishes and maintains a register of patients with established hypertension	6	
Ongoing management		
HYP002. The percentage of patients with hypertension in whom the last blood pressure reading (measured in the preceding 9 months) is 150/90 mmHg or less	10	44–84%
HYP003. The percentage of patients aged 79 or under with hypertension in whom the last blood pressure reading (measured in the preceding 9 months) is 140/90 mmHg or less *NICE 2012 menu ID: NM53*	50	40–80%
HYP004. The percentage of patients with hypertension aged 16 or over and who have not attained the age of 75 in whom there is an assessment of physical activity, using GPPAQ, in the preceding 12 months *NICE 2011 menu ID: NM36*	5	40–80%
HYP005. The percentage of patients with hypertension aged 16 or over and who have not attained the age of 75 who score 'less than active' on GPPAQ in the preceding 12 months, who also have a record of a brief intervention in the preceding 12 months *NICE 2011 menu ID: NM37*	6	40–80%

Figure 2.2. QOF indicators and sub indicators for hypertension: criteria, standards and points allocation, 2013/14 contract. Source: BMA, NHS Employers, & NHS Commissioning Board, 2013.

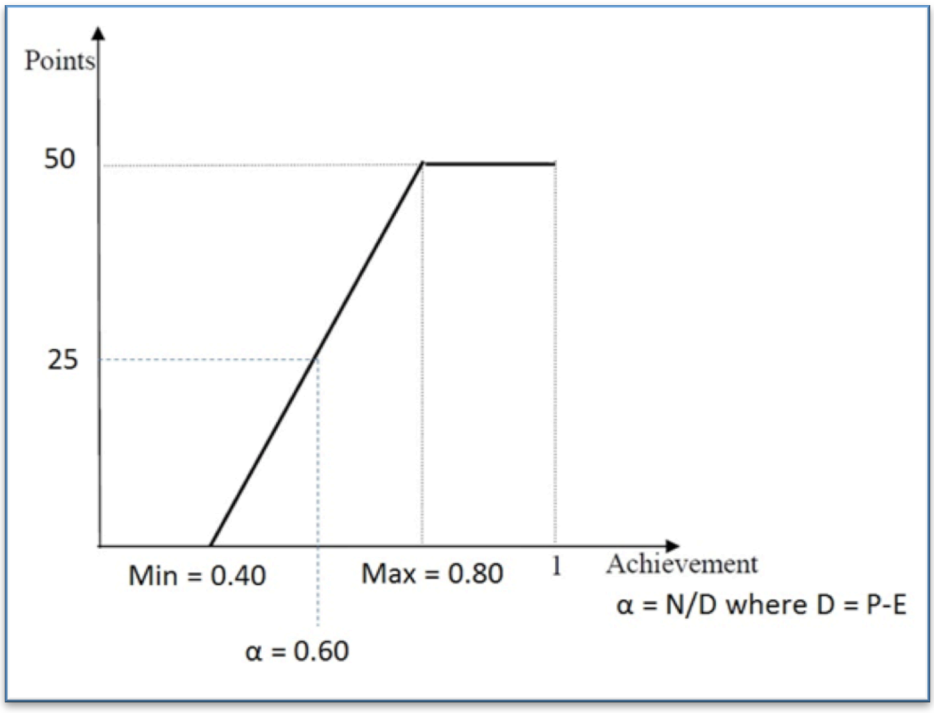
The clinical criteria were transformed into 'clinical indicators' and each corresponding standard into an 'achievement threshold'. Each clinical indicator is allocated a certain number of points. Policy-makers can prioritise certain clinical areas by allocating more points to certain targets. This can have an inductive power, further discussed in Chapter Five. The mathematics of QOF points-scheme operates in accordance to the logic of proportion and exclusion. The former is a relational process based on ratio and range of achievement. The latter is a safety net predicated on exception reporting.

Ratio and range of achievement

According to QOF rules of proportion it is possible to measure the quality standard using the criteria of ratio and range of achievement: (1) The ratio is the proportion of the number of patients registered for that particular indicator (numerator) in relation to the number of treated patients in accordance to the established criteria (denominator); (2) The range of achievement is determined by minimum and maximum cut-off points, which express the quality standard acceptable for that particular clinical indicator.

The minimum cut-off point refers to a threshold below which practice performance is considered as very poor, whereas setting a maximum cut-off point below 100% is recognition that not all patients (for whatever reason) included in a particular clinical indicator measurement can be achieved. These two components (ratio and range of achievement) are used for calculating the level of achievement for each QOF indicator. For example, QOF hypertension indicator (HYP003) states the following audit criteria: 'the percentage of patients aged 79 or under with hypertension in whom the last blood pressure reading (measured in the preceding nine months) is 140/90mmHg or less'.

The desired quality standard is an achievement between 40 to 80% of the target registered patients and QOF offers 50 points for this newly introduced indicator (Figure 2.2). For instance, if 60% of the target patients enlisted in a general practice record a blood pressure of 140/90mmHg or less in the previous nine months, the practice will receive 20/40 (i.e. half of the points available [25 points] since 20 corresponds to what exceeds 40% of the lower threshold – Graph 2.1).



Graph 2.1. QOF points-based system logic. Source: adapted from Gravelle et al., 2008.

The Graph 2.1 demonstrates the linear increase in point achievement according to the proportion of target patients treated, varying from a minimum (Min.) and maximum (Max.) threshold. The level of achievement (α) can be expressed as ratio: α = N/D. The numerator (N) is the number of registered patients who fit into the particular QOF indicator criterion, whereas the denominator (D) represents the number of patients (P) treated (the standard reached) according to the indicator criterion minus number of exception reporting (E). The latter completes QOF mathematical logic: the exception reporting.

Exception Reporting

The QOF exception reporting is an important component in the mathematics of its points-scheme (Table 2.3). Designed as a safeguard for patients, the exception reporting aims to avoid 'harmful treatment resulting from the application of quality targets to patients for whom they were not intended' (Gravelle, Sutton, & Ma, 2008, p. i). In the 2013/14 contract it states that "Exceptions":

> Relate to registered patients who are on the relevant disease register or in the target population group and would ordinarily be included in the indicator denominator, but who are

> excepted by the contractor on the basis of one or more of the exception criteria. [Table 2.3] (BMA, NHS Employers, & NHS Commissioning Board, 2013, p. 8)

The exception reporting criteria summarised in Table 2.3 are an essential part of the QOF scheme. For instance, item one means that a practice either has to send three letters of invitation or use telephone calls to invite patients, and register these invitations in patients' records, in order to demonstrate that they tried to bring the patient to a clinical review. In regard to item six, patients' dissent decisions have to be registered in their records 'following a discussion with patients' about a proposed treatment (BMA, NHS Employers, & NHS Commissioning Board, 2013, p. 8.).

Table 2.3. Summary of QOF main criteria for exception reporting.

1.	Patients who refused to attend review after being invited on at least three occasions during the financial year.
2.	Patients who are inappropriate to treat/review such as those with terminal illness or extremely frail.
3.	Patients newly diagnosed or who have only recently registered with the practice.
4.	Patients who are on maximum tolerated doses of medication whose levels remain sub-optimal.
5.	Patients who have medication side effects (i.e. allergy) or a clinical contra-indication or have not tolerated medication.
6.	Informed dissent where patients do not agree to investigation or treatment.
7.	Where an investigative service or secondary care service is unavailable.

Source: Adapted from BMA, NHS Employers, & NHS Commissioning Board, 2013, p. 8.

The QOF rules, as discussed above, show a range of flexibility that has concerned policy-makers and researchers alike. It allows for manipulation of the data, either by changing the numerator or denominator, for the practice to gain financially. This has being referred as 'gaming' (Gravelle et al., 2008, p. 2). To reduce the chances of gaming, an annual inspection is carried out by what used to be the Primary Care Trust (PCT), after April 2014 replaced by the Clinical Commissioning Group (CCG). This usually includes a GP with managerial position (Roland, 2004), however the available budget limits thorough 'inspections on statistical outliers' (Doran, Fullwood, Reeves, Gravelle, & Roland, 2008, p. 283). The QOF end result points are dependent on how QOF data is gathered, implying an interaction

between professional staff and IT system software packages, a key element for running this clinical quality scheme.

Information technology system

The NHS information technology system improvement was at the central agenda of the New Labour government. For instance, in 2002 the department of health (DoH) launched a national strategy programme, 'Delivering 21st Century IT Support for the NHS'. One of the aims of this IT improvement was to strengthen the clinical governance in the NHS:

> For health care managers reliable, accurate data (financial and clinical) will enable better workforce planning and management of scarce resources, will improve clinical governance and promote high quality care. Public Health, the planning of services for populations, as well as analytical and statistical services will be based on better quality data. (DoH, 2002, p. 2)

In the 2004 GMS contract package, the IT system was financially supported by a 'mix of one-off financial incentives for practices to develop their IT infrastructures through additional contract payments […and for adopting] IT systems in connection with the QOF' (Peckham, 2007, p. 40). The QOF scheme has boosted the wide use of electronic patient records (EPRs) which have enhanced the coding process, making it both easy to search and transport patients' data as well as for the business of clinical and organisational performance indicators (Swinglehurst, Greenhalgh, Myall, & Russell, 2010, p. 3).

Without an efficient IT system it would be nearly impossible to process the amount of information built into this managerial 'quality' framework. The size of information exchanged is huge, since 'the data for QOF is collected from almost 8,000 GP practices with over 56 million registered patients in England' (HSCIC, 2014a). On the one hand, QOF needed changes in both the episteme of medicine (with the introduction of EBM) and political scenario (with an internal-market arrangement) to be broadly embraced. On the other hand, at the practical level it was predicated on the availability of a robust IT system. This allowed for the materialisation and realisation of an efficient clinical governance framework. In the NHS webpage 'your health and care records' the motto is "better information means better care" (NHS, 2014). The UK government aims to build a big database that can be used for quality assurance appraisals of the care being provided, as well as to 'better understand diseases and *develop drugs* [emphasis added] and treatments that can change lives (NHS

England, 2015). Thus, IT systems represent a complex agenda with multiple actors involved in health information management, analysis, and research.

The introduction of IT systems has changed both general practice management and the consultation style. General practice management has diverted its focus towards 'data collection' and 'efficiency' (Checkland, 2004) in order to secure practices' revenue. Therefore, general practice consultation has now been practically all computerised and GPs' and nurses' consultation style is informed by computer programmes' 'prompts' and 'reminders' 'to ensure that patients have had a variety of tests and screening at each visit' (Peckham, 2007, p. 40).

Different software packages are available on the market for general practice to keep patients' and practices' data in accordance to the practices' recording needs and government requirements. For instance, a standard terminology of coding system was created for general practice known as 'Read code' for QOF coding which is regularly maintained, updated and collected by the Health and Social Care Information Centre - HSCIC (Swinglehurst & Greenhalgh, 2015). All the above QOF rules are codified by practice's software and organised by icons, headings, colours and prompts, in order to improve patients' disease management compliance and obtain the information needed for securing practices' income. This interface with IT system will be explained in more details in Chapter Four.

As discussed throughout this chapter, the IT system development and the massive use of EPRs should be placed within the historical background of the 'evidence-based medicine movement, clinical governance, rising managerialism and a general move towards valuing standardisation and eliminating what are perceived to be undesirable variations in care' (Swinglehurst, 2014, p. 18).

CONCLUSION

This chapter has contextualised the Quality and Outcomes Framework as health technology by delving into the nature of general practice and the roles played by different contractual arrangements in defining quality and in shaping general practice itself. In this regard, it offered an understanding of the context of general practice, its cultural distinctiveness, and the role played by different political actors. Specifically, it discussed how powerful forces

(economic and political), as well as epistemological (in the case of evidence-based medicine) and technological (with the availability of IT informational systems) have transformed general practice, so that today it is under the strong grip of clinical governance. The QOF scheme is part of this clinical governance environment, which prompts and relies upon a scientific-bureaucratic model of practicing medicine that allows greater scrutiny, accountability by government agencies and standardisation of care.

This chapter also gives an overview of the main items embedded into the 2004 contract that has represented both economic gains and workload reduction for general practitioners (e.g. given up out-of-hours 24/7 commitment). Therefore, QOF was accepted as part of overall potential economic advantages, backed by a quality discourse of practicing medicine in accordance to EBM model. After contextualising the QOF scheme, it outlined its transformation over time, domains and rules in relation to a points-based system that combines ratio, range and exception reporting for reaching the agreed targets.

Lock and Nguyen (2010, p. 22) have stated that anthropologists should explore 'taken-for-granted objects of knowledge in the world of medicine, public health and health policy and their use in practice'; or in other words, 'the ways in which various practices and technologies are legitimated, and in particular the value judgments (often unrecognised) embedded in this type of discourse […] which sees biotechnologies [in this case, the QOF scheme] as 'things-in-themselves, and therefore ethically and morally neutral'.

As anthropologists, we need to apply Lock and Nguyen's premise by going inside, observing, and exploring the everyday life of medicine in general practice under the influence of QOF. Thus, this 'quality' scheme represents a clinical governance health technology boosted by a very sophisticated IT system, which needs to be scrutinised from a different angle. Chapter Three describes the methodological approach applied to studying QOF.

Chapter Three

FOLLOWING THE QOF: ETHNOGRAPHIC STUDY OF GENERAL PRACTICE IN BRITAIN

> It is a question of analysing a "regime of practices" - practices being understood here as places where what is said and what is done, rules imposed and reasons given, the planned and the taken for granted meet and interconnect. (Foucault, 1991b, p. 75)

The complexity of UK's primary health care services requires a qualitative methodological approach capable of better capturing QOF's effect on general practice. In this case, an ethnographic study is ideal to explore the QOF scheme, as it can provide 'rich and holistic insights into people's views and actions' (Reeves, Kuper, & Hodges, 2008, p. 337). This methodological approach is one of the core contributions of anthropology to the scientific investigation and is considered a more robust qualitative research design for presenting its findings to a broader audience (Murphy, Dingwall, Greatbatch, Parker, & Watson, 1998). Its flexibility gives ethnographic methods the necessary adaptability for studying the interface between health professionals and technologies (Swinglehurst et al., 2010). In other words, ethnography continues to evolve, finding its applicability to complex scenarios such as biomedicine and health related technologies (Lock & Nguyen, 2010).

This chapter describes the processes in conducting an ethnographic study in UK general practice. Firstly, it discusses the research settings, site selection, and the process of being allowed into GPs' surgeries. Secondly, it briefly describes the complexity of UK primary care followed by the research sites description. Thirdly, it explains the data collection and analysis procedures followed by a reflective process. Fourthly, it addresses the ethical considerations of carrying out ethnography under the ethical and clinical governance environment of the NHS. Finally, it presents the induction phase into general practice by being accepted and 'equipped to navigate' in the GPs' realm. This helps to contextualise the reader for the following thematic ethnographic thesis chapters.

RESEARCH SETTINGS

Site selection process

The main unit of analysis involved two primary care services known in the UK as general practices, or simply GP surgeries, and the health staff working under the influence of the Quality and Outcomes Framework scheme. Ideally, qualitative studies seek to understand the uniqueness of individual cases trading breadth for depth (Murphy et al., 1998). However, the reality of this ethnographic study was constrained by resources and the timescale required by both PhD completion and QOF financial year. Hence, the methodology chosen for selecting the research sites was non-probabilistic and pragmatic (Kuper, Lingard, & Levinson, 2008), based on the availability and practice team's willingness to take part on the research project.

The QOF schemes' successful implementation across the country and the high levels of QOF point achievement by GPs (Campbell, McDonald, & Lester, 2008) suggest that this managerial tool is being consistently used. Despite general practice being a culturally diverse environment, the same cannot be said with regard to QOF managerial strategies where similarities tend to be greater since they cluster around QOF rules. Consequently, the phenomenon being studied is likely to allow for case-to-case transference and the generalisation of the main research findings (Murphy et al., 1998), albeit through studying just two surgeries.

The National Health Service's ethical clearance and Research Governance approval did not guarantee easy access to general practice surgery (GPS). As discussed in Chapter Two, after Thatcher's conservative government, the NHS was turned into a quasi-market organisation and since its foundation GPs hold an independent contractors status. As independent contractors, GPs can accept or reject any research proposed to be conducted in their premises. This arrangement resembles a private contractual relationship rather than a unified public administrative institution. Therefore, despite the interest in this research project by the Primary Care Trust (PCT), the recruitment of two participating GP practices turned out to be one of the most difficult steps during the initial phase of my fieldwork. Obtaining GPs research consent was much harder step than the bureaucratic process of fulfilling the ethics requirements for research carried out within NHS institutions.

The first attempt involved contacting practice managers of some GP surgeries via letter, email, and phone. This initial orientation was given by a retired GP involved in the

ethics committee of Durham University's Anthropology Department. However, after some letters and emails went unanswered, my strategy changed to find some way of becoming personally known to the general practice context to gradually gain GPs' trust in order to be accepted in at least one GPS. This led me to be introduced in the GP training programme.

GP training programme: a satellite research space

In order to become a qualified GP in the UK doctors have to go through a specialty training programme. This includes practical medical training both in general practice and hospital settings, as well as coverage of theoretical curriculum content (RCGP, 2010). The specialty training programme is under the organisation Health Education England (HEE). This institution is decentralised across the country in various main regions, which harbours several GP Training Programmes (GPTP). The GP training programme includes a half-day release (HDR) theoretical programme, which is meant to cover relevant content as the trainee physicians specialise to become qualified general practitioners. In this three-year training scheme, GPs are taught clinical, ethical, managerial, and financial topics. The content is distributed according to GP trainees' needs and the teaching methodology is mainly self-directed or problem-based learning.

The GPTP prepares GP trainees for passing two mandatory national exams: the Applied Knowledge Test (AKT) and Clinical Skill Assessment (CSA). The latter is based on GPs' ability to communicate effectively in a 10-minute consultation in accordance with the Calgary-Cambridge model (Silverman, Kurtz, & Draper, 2005). The CSA is one of the toughest test GPs have to undertake and they have just four attempts to succeed at it. If trainee GPs fail to pass this exam, they cannot work as qualified GPs in the UK. The CSA reinforces the importance of the doctor-patient relationship as a core value for defining this field of medicine (McWhinney, 1996). For this reason, the GPTP provides extra-afternoon sessions to prepare GP trainees for the CSA. Additionally, for those GPs who graduated abroad, the GPTP offers six special sessions (roughly eight hours each) called 'closing the gap' to help these GP trainees to overcome the differences between UK medical and general practice culture with their previous medical background. 'Closing the gap' sessions address themes such as sexual education/behaviour, pregnancy termination, contraception, teenage group behaviour, drug misuse and abuse and so on. Doctors with different backgrounds might have difficulties handling these issues due to various factors such as religion, culture and lack

of awareness regarding the UK clinical governance and legal framework behind each of these clinical contexts. Personally, these sessions were quite helpful for me to improve my understanding of UK general practice as well.

General practitioners can be considered 'hard to reach' research targets, since they are usually constrained by the time pressures of both clinical practice and patient workload. Additionally, they 'employ staff which act as gatekeepers', such as managers and administrative staff, preventing a direct access to them (Cheraghi-Sohi, 2011, p. 117). Additionally, their status of independent contractors puts them into a powerful relation within the NHS structures, making it even harder to have them on board in a research project. Hence, the adopted strategy was to become known by a network of GPs through the GPTP in order to receive the acceptance of two GP surgeries as research settings. However, as the research progressed I realised that the GPTP was an invaluable source of research data on QOF in its own right. Eventually, this space became what I have called a satellite research site.

The first 'face-to-face' contact with the GPTP was on 22nd May 2013, when I was introduced to a group of GP training programme directors. These GP directors are responsible for delivering most of the theoretical content of the GPTP. They offered me the opportunity to deliver a 10-minute presentation at the GP trainers' seminar to be held on 3rd July 2013. After that, I received the permission to attend the training scheme from 14th August 2013 onwards. The GPTP space offered information, reflection, and acculturation into UK general practice. In this training environment GPs speak more freely about political issues and the challenges of their profession. The relation between audit and the QOF scheme is closely connected and GP trainees need to demonstrate that they understand the principles of audit, usually by doing an audit themselves. In the UK, audit as content was introduced by the Royal College of General Practitioners into GP training programmes in the 1990s (Roland, 2011). Audit and QOF are part of the concept of quality improvement, and for this reason they are considered important topics in teaching sessions. Additionally, managers and accountants are commonly invited to discuss with trainees the challenges of running a general practice and its financial requirements.

For the research project, I attended most of the third year specialty training programme covering the following subjects: (a) clinical governance and safety; (b) clinical

health related topics (e.g. physical and mental disabilities, drugs and alcohol, autism, etc.); (c) career choices (salaried contracts vs. partnership agreements); (d) CVs and interviews; (e) practice management; (f) organisation of practice; (g) appraisal and revalidation; (h) Balint group[2]; (i) practice accounts; and (j) commissioning. By attending these course modules, my understanding of the financial and managerial aspects of general practice enhanced, as well as allowed me to observe how GPs are formed in the UK under a strong clinical governance environment.

The Figure 3.1 shows a 'spider-net' resulting from a tutorial discussion around patients with 'learning difficulties'. The 'spider-net' organises a brainstorming process with regard to the theme, as well as a work division for studying and presenting the topic for the group in the next tutorial. The top right-hand corner of the picture highlights that GPs' role entails the QOF scheme. As QOF has become an integral part of GPs' duties, GP trainees are constantly reminded of QOF requirements during their training programme. Attending the training scheme, participating in the programme's modules, and speaking to GP trainees, GP trainers, managers and accountants all contributed to better understand QOF and its importance for general practice in the UK.

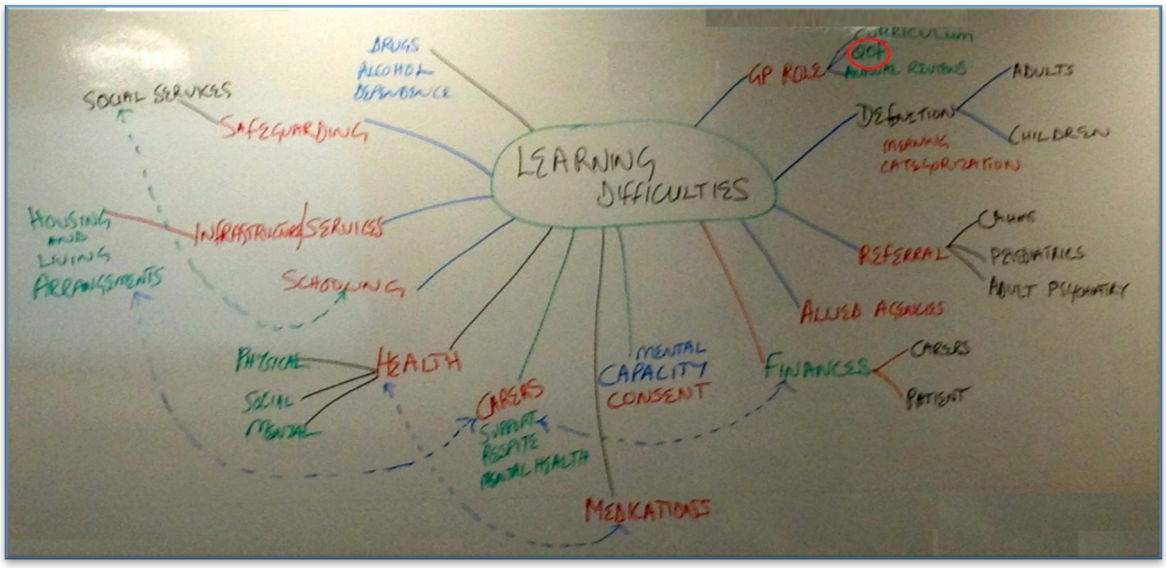


Figure 3.1. 'Spider-net' on patients learning difficulties and QOF as one of GPs' role [QOF highlighted by the author].

[2] Balint groups (after Michael Balint GP and psychoanalyst) are usually small, intimate spaces for GPs to get together and discuss a difficult case (brought by a case presenter). This should be freely explored and reflect 'with the help of colleagues' on 'the possible roles that they have assumed with patients' (Johnson, 2001, p. 177).

Additionally, this space provided the opportunity for a focus group, which will be described later in this chapter. Being in continuous contact with GPs helped me in gaining access to two general practice surgeries in Britain. The whole process from being introduced into the GPTP, getting accepted by two GPS and the completion of the fieldwork in April 2014 is summarised in Table 3.1.

Table 3.1. Steps taken to get into two general practice surgeries until the fieldwork completion, 2013/14.

1) Through an exchange of emails with key informants I was put in contact with a GP director of a GPTP, in May 2013.
2) The GP director agreed to see me in May 2013, when I was introduced to the group of GPs. They allowed me a 10-minute presentation at GP trainers' seminar to be held in July 2013.
3) In July 2013 I gave a PowerPoint presentation explaining to an audience of about 30 GP trainers my research project and the importance of this topic for the NHS and the Brazilian Unified Health System (called in Portuguese *Sistema Único de Saúde* - SUS), since the NHS has a good international reputation in terms of public and universal health care system with free access at the point of delivery.
4) After my talk, one of the GPs became interested in the project and agreed to talk to his partners to find out whether they would accept my research project.
5) This first contact facilated a meeting with one of the GPs partners, who worked for the same GP medical group that had showed interest in my research and put me in contact with him. This GP eventually became one of my main gatekeepers ("A").
6) The first meeting with the gatekeeper "A" was in July 2013, in which I explained my research project: an ethnographic study exploring the effects of the QOF scheme in the UK general practice, which intended to cover the end of the financial year ending on 31st March 2014. We had a conversation, which lasted about an hour and he was quite willing to talk to his partners as well.
7) Although the gatekeeper "A" was my primary contact for getting into the research site and we started to exchange numerous emails, I made little progress in becoming formally accepted by the other GP partners. However, this dialogue resulted me being signposted to another GPS as gatekeeper "A" introduced me, via email, to a manager of a second medical group, opening the possibility for conducting my research in another GPS.
8) In July 2013 I met with the manager of the practice 'B' and we have a long conversation about my research project. There was an agreement on the anthropological research in studying the QOF scheme, but also the need to further analyse the research project itself. Then, via email exchange my research project was forward to the practice's medical director (MD). The GP MD ended up being the main gatekeeper for practice 'B'.
9) Access to the GPSs consumed much of my time in 2013 and the delay in getting in prompted me (and my first supervisor as well) to consider other alternatives to my research project, for example, doing my fieldwork in the GPTP or carrying out interviews instead of ethnography solely.

10) Being in contact with GPs mainly during GP trainer's meetings, which were held every two months, and liaising with them via email increased my presence and contact with them. Thus, through this long dialogue with the two medical groups - and through different communication channels - I eventually got accepted by the first GPS on 4/11/2013, and by the second GPS on 5/12/2013.

11) From 4th November 2013 onwards, I attended the first research site on a daily basis, except on Wednesdays, because I continued attending the GPTP.

12) From 5th December 2013 onwards, I began to rotate amongst the three research sites: Mondays and Tuesdays with the first GP medical group, GPTP on Wednesdays, and on Thursdays and Fridays I attended the second GP medical group. This routine was flexible allowing me to swap between GPs' practices according to QOF related activities that were offered or rendered more information for my research.

13) On 22/12/2013 my first supervisor and I agreed on a Christmas break, with my research activities restarting on 16/01/2014.

14) Resuming my fieldwork in January 2014, I then decided to focus mostly in the second GP group, but gradually in February I restarted the same initial rotation between the three research sites.

15) My fieldwork in the first GP medical group finished on 20/03/2014 and on 03/04/2014 I finalised my activities with the second GP medical group. The latter allowed me to attend the new QOF requirements meeting and planning for the coming financial year 2014/15.

Two British general practices' profiles

The NHS has a very robust primary care system compared to many other countries, ranking first for providing an 'effective, safe, coordinated, and patient-centred care' (McCarthy, 2014, p. 1). British population satisfaction with GP services ranked high in a recent public satisfaction survey, being the most popular sector of NHS, with 71% of approval amongst the surveyed people in 2014 (The King's Fund, 2015). Furthermore, general practitioners perform an important role in the intricate network of care providers and can be considered a hub for coordinating patients' care throughout this complex health system (Press, 2014).

Different groups of professionals orbit through and around general practice. For instance, counsellors use the GP surgeries to see their patients; district nurses utilise GP surgeries as a base for caring for housebound patients, registering their activities and getting material support for carrying on their tasks (i.e. material for dressing), putting them in close relationship with GP practice teams; school nurses may also see teenagers in GP practices to

strengthen the connection with this age group and available services; and health visitors might utilise the GP premises for well-baby follow up.

Thus, general practitioners are responsible for coordinating care using local community health resources wisely. These resources include mental health crises teams, palliative care teams (Macmillan nurses), Chronic Obstructive Pulmonary Disease nurses and matron nurses who all care for more complex cases in the community to avoid hospital re-admission. Furthermore, most referrals to secondary and tertiary level within the NHS are done through the general practice health care team. Thus, QOF should be placed within this complex scenario.

The two GP practices in this study are in fact practice groups. They provide a training space for medical undergraduate students, foundation programme doctors of first and second year (F1 & F2) and GP registrars of first and third year (GPs enrolled in specialty training programme - ST1 and ST3). Practices must have high quality standards of care to host training programmes, and consequently high QOF scores achievement. This was explained by a GP, as follows:

> *'I think, that kind of people that we are though, mean that…we want to get the Quality and Outcomes Framework targets. You see, it's…there is a kind of kudos to be high QOF achieving practice, and indeed, to continue to be a training practice, in terms of training standards, if you do not get high achieving on Quality and Outcomes Framework you will <u>not</u> be reaccredited as a trainer. So, so…my practice has... at the moment my reaccreditation is next summer, so <u>I must</u>…my Quality and Outcomes Framework <u>must</u> be high…'* [GP2]

Both surgeries provide services to a registered patient population of circa 16000 patients (varying from 15000 to 17000), which is considered a big practice group (Checkland & Harrison, 2011). The research site 'A' encompassed four branches, whereas the research site 'B' comprised of two branches. The first surgery is located in a semi-rural type of community, whereas the second surgery is placed in an urbanised town with big supermarkets and a commercial centre. In general, both surgeries cover a considerable number of deprived areas, but one of them clearly covered an affluent community as described by a member of administrative staff:

> *'Generally speaking* [this community] *is probably quite affluent and there's lots of money, whereas further up the boundary that you go…there's much more people living on benefit and, so they have more health issues then they have at this end.* [This community] *tends to have*

the worried well and [the other] *end tends to have the generally sick people, you know, through lifestyle or whatever…so that's where all deprivation on the north side of the practice are mostly'.* [MF1]

The level of social deprivation and people depending on government benefits in both sites reflect the socio-economic changes largely after the closure of the coal mining industry, also known as 'the pits'. This seems to have had a great impact on community mood, creating a snowball effect on subsequent generations, as described by a nurse who worked in the community for a long time:

'Motivation is pretty poor…hmm…in some cases, the elderly…funnily enough are better…in [our place] *they seem to…they attend more, they seem to attend more, there's not many that fails to attend over here…the younger people…in this area tend to be young… younger with the chronic diagnosis…unemployed…hmm…probably not in their own house, probably in rented accommodation. I know that it's…you know, it's not good labelling them, but we've got a lot of patients now, who live in our community that have never lived here most of their lives, that they moved from lots of other parts of the country…hmm…because of the landlords having lots of properties in* [our place] *from when the pit closed, so we've got patients that have come from London, patients that have come from Scotland…and they all seem to have been…dropped in* [our place], *so we've got a mixed bag…of people who've probably come here…hmm, for housing initially, sort of in rented accommodation…hmm…I don't know whether they've come here for work…but there is no work…so, they may have been…you know…sort of sold…the fact that: "there's housing there, there might be an opportunity for you", but when they get here there's no work for people to apply for…so, it's…hmm…it's…it's quite a lot of…unhealthy chronic diseases…in younger people'.* [N3]

The Care Quality Commission (CQC) is responsible for overlooking general practice standards in terms of structure, health and safety, staff training and so on, in order to secure and/or improve the quality health care premises. In general, both premises were operated in accordance with the requirements and in the main surgeries computerised self-check-in devices were available to facilitate patients' access to their appointments. This shows how modernised are these two research settings. Both have websites, which allow patients with the resources and Internet to access the main information about the GP surgeries.

Despite these apparent similarities, internally these medical groups function very differently: in one practice GPs were the contract holders and were responsible for employing

other health and administrative staff, whereas in the other practice all staff, including GPs, were salaried, with some of them being shareholders. In other words, within practice 'A' GPs were the main employers and in practice 'B' they were all employees. I got the impression that power relations in the salaried model (practice 'B') were more equitable between managers, nurse practitioners and general practitioners, whereas in the partnership model (practice 'A') GPs were clearly in power.

The different business models created different atmospheres: the partnership model was more like a 'family business', whereas the salaried model resembled more a 'company model'. The former tended to be entangled with personal issues amongst the partners with QOF monetary implications frequently openly discussed in the practice meetings. The latter had a clear hierarchical organisational arrangement, being a company model, but at the practice level it seemed to have a sort of participatory model in running the practice activities. This 'company model' apparently resulted in less personal and finance involvement, with QOF demands being phrased in terms of points and not so much in regard to their monetary implications.

Another difference between the two practices refers to chronic disease management. In practice 'B' the chronic disease management was organised through the nurse team, whereas the practice 'A' had a mix of GPs and nurses involved in chronic disease care. This difference was well described by a general practitioner when comparing site 'A' with her previous job, which used to have chronic disease management via the nursing team, similar to the practice 'B' approach:

> *'Their chronic disease management* [which is similar to practice 'B'] *is much better, because it's entirely driven by nurses and health care* [assistants]*…that's part of their job…(.hh)…so everybody who's got chronic disease, whether that is COPD, diabetes, mental health…(.hh)…they come in… they get recall on their birthday month…and they come in…and they have…*[their review]*…but they don't come in to doctors, because that's what's happens here* [in practice 'A'], *we* [GPs] *get COPD reviews booked in, but I haven't got a FVE1* [Forced Expiratory Volume in the first second], *I can't do that; so, they have…they have a kind of partial review and then you ask them to come back just to…(.hh)…have an FVE1, whereas actually…(.hh)…most of what needs to be done for QOF can be done by the nurses and…it might be just a telephone consultation that you need with the doctor…if everything is OK…'* [GP8]

Both practices had experienced important changes in staff due to sick leave, retirement, or nursing staff moving to other job opportunities, which resulted in part of their work being covered by locums and/or salaried GPs. As nursing staff changed in both practices this contributed to issues around QOF training and difficulties in coding and registering QOF related activities properly, as described by a nurse:

> *'I don't know if you picked up on this…like the* [manager] *said…this year we've been particularly hit with…changes in doctors…we've had a massive turnover in our doctors team, alright…on nursing team, we've had a massive turnover in our nursing team…we've had a lot of highly trained nurses that all left…right in the beginning of the year, we have practically a new nursing team…this year…hmm…now our health care assistants are hit by the same problem…they've got…we've got one on long term sick and we've got one that's left. So, that's two out of our team…*[of] *health care assistants that…were down, you know…'* [N2]

In general, both surgeries have longstanding good local and peer reputations. One of them received a RCGP quality practice award in previous years. These two surgeries, however, rather than being seen as separate entities, I would argue, can be understood as one space: the general practice environment. Each practice offered complementary input in regard to QOF: spaces and contexts that were not covered (or difficult to reach) in one surgery were covered in the other surgery and vice-versa. This complementary nature might be the result of different time entrance into each fieldwork setting, a month apart from each other, and different contractual arrangements. For instance, after the first week the partnership model practice (practice 'A') allowed me access to its QOF business and financial framework, a kind of data that I could not get or even encountered in practice 'B' due to its multi-layered managerial and hierarchical organogram arrangement. The main characteristics of both research sites are summarised in Table 3.2.

Table 3.2. Practice 'A' and practice 'B' main characteristics in 2013/14.

Main characteristics	Practice 'A'	Practice 'B'
QOF overall achievement 2012/13	98.4%	99.6%
Training practice	Yes	Yes
Population size	15000	17000
Personal list of patients	No	No
Socioeconomic	The main surgery caters for upper economic social class while the remaining three surgeries cover more socio-economically deprived areas.	The main surgery caters for a mix of social economic classes though socio-economically deprived predominates. The second surgery clearly covers a very deprived community.
Branches	Four	Two
Business model	Partnership	Salaried
Chronic disease management	Mixed of GPs and nurses led services.	Mainly a nurse team led clinics.

Source: elaborated by the author.

The fact that the research was informed by three different scenarios, allowed me to cover the research object from different angles. It can be characterised as a multi-sited approach whereby 'an object or phenomena selected for investigation can be described, including the perspectives of experts, policy-makers and practitioners (Lock & Nguyen, 2010, p. 9). Despite the fact that my fieldwork lacked the policy-maker space and remained in the context of general practice, it offered different spaces (practice 'A' four branches, Practice 'B' two branches, and the GPTP). The sites within those spaces provided a variety of expertise levels such as in GPTP (GP training directors, GP trainers and GP trainees), managerial spaces (practice meetings and QOF team meetings), administrative staff working places, and clinicians' rooms (general practitioners, nurse practitioners, practice nurses and health care assistants).

These multi-layered sites allowed for a data triangulation process whereby 'different sources of data [are used] to examine a phenomenon in several different settings and different points in time or space (Reeves et al., 2008, p. 531). This context has facilitated a better understanding of QOF managerial influence over general practice by 'following the QOF' through different places.

PROCESS OF DATA COLLECTION

As the objective of the present research was to explore the consequences of the Quality and Outcomes Framework in general practice, various techniques were applied for data collection. When I started to take part on the GPTP, by attending the ST3 trainee modules and shadowing the training programme directors, the observation and fieldnotes taking process started.

The process of registering/documenting the fieldwork was done on an iPad mini. This is a very light and convenient gadget with flexibility for switching modes from typing on the spot to recording or image taking such as photo and video. By carrying it with me all the time and it being normal nowadays to open and type and flick around its content, the participants got used to my behaviour. Thus, I was able to write down any idea that came to me or any utterance voiced by participants that caught my attention, as 'quoting' what one has said. It allowed for electronically-recorded fieldnotes boosting my time and giving more accuracy when describing the content of interactions within the general practice environment.

One of the methods I used in the GPTP was to carry out a focus group, since in that particular space general practitioners enjoyed a more flexible schedule. The focus group was carried out on 30th October 2013 just before I started the fieldwork in the GP surgery 'A'. This activity was conducted in a private space within the GP training centre and included four experienced GPs. I adopted a non-directive approach to the focus group in order to explore potential new themes and by giving space for all participants to contribute in the discussion. The focus group lasted 56:52 minutes being audio-recorded and transcribed in full and all participants signed an informed consent form (Appendix A). The focus group helped me to expand the reasons for QOF being introduced, possible themes to explore during the fieldwork, as well as clarified some of QOF's operational aspects.

During my fieldwork I was always observing and, depending on the context (e.g. non-clinical), I had a degree of participation such as: in some of GP trainee workshops or QOF

meetings; by helping administrative staff folding patients' letters and putting them into envelopes; and searching in patients' electronic notes for amending QOF coding issues. When possible, I asked permission to record the participants' QOF related activities. Thus, I got the opportunity to record the following QOF-tasks: (a) QOF meetings; (b) QOF recoding/amendment sessions; (c) doing QOF over the phone; (d) private explanation on QOF operational system; and (e) training session on QOF for a new member of staff, which was video recorded. These recordings were not formal interviews, but recording of real-life interactions with health staff as they dealt with QOF issues and the activities at hand. When there was no favourable context for recording, such as in clinical consultations involving patients, fieldnotes of these activities and pictures of QOF-related computer screen were taken. As mentioned above, I just used the e-tablet on my lap and typed the things that caught my attention on the spot.

Being around and about in GP surgeries, there was always an opportunity for informal conversations with members of staff at the reception area or at the kitchen. As they became familiar with my presence I managed to interview some of them as well. Since these professionals were very busy, I carried out interviews in their own working space such as consultations or office rooms. I used whatever time was available and consequently the time span of interviews/conversations varied considerably from 12 minutes to 8 hours (when it was mixed with QOF session activities, such as amending codes). Another data source were documents - either official statements (GMS contracts) or results of computer screen pictures, practice portfolios, websites or even a flipchart left in the practice meeting room with information on the GP surgery's QOF points achievement progression.

Being one researcher in three different settings that harboured various inner spaces, I tried to maximise my contact with potential sources of information by covering three main dimensions: (1) Time - being in the research settings on different days of the week and times (morning and afternoon); (2) People - being in contact with the main people involved with QOF (i.e. administrative staff, managers, nurses and doctors); and (3) Spaces within settings - attending the GPs modules on Wednesdays, and observing the surgeries daily work (i.e. managers, administrative staff and receptionists spaces; GPs' and nurses' consultation rooms; minor operation rooms; patients' homes, and nursing homes).

To remain focused while researching in this diverse environment of general practice, my strategy for data collection was to turn QOF into a compass to keep me on track during the fieldwork. As general practice became one big research environment, scattered in three sites, an approach to multi-sited ethnography by 'following the thing' was quite inspirational:

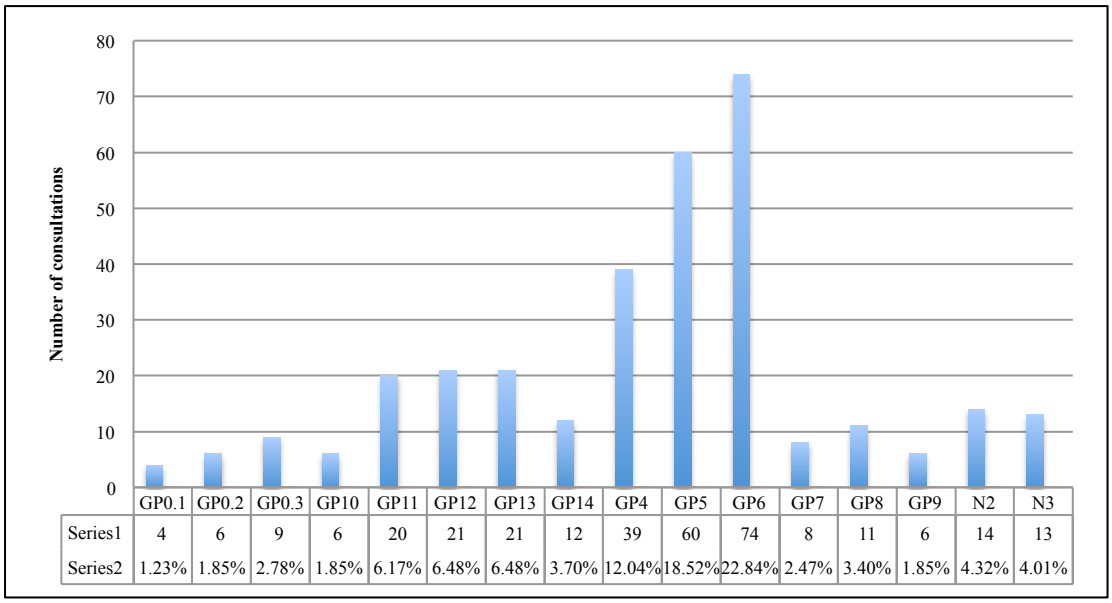
> This mode of constructing the multi-sited space of research involves tracing the circulation through different contexts of a manifestly material object of study (at least as initially conceived), such as commodities, gifts, money, works of art, and intellectual property. This is perhaps the most common approach to the ethnographic study of processes in the capitalist world system. (Marcus, 1998, p. 91)

Although my object did not actually move across sites, it was conflated by its virtual nature being materialised and embodied through intricate interactions amongst computer software/screen, people's roles, and spaces. All of that orbiting about QOF as satellites, made me select the 'following the thing' path to define, arrange and present general practice. In this regard, the QOF scheme has largely been responsible for organising general practice into two complementary professional roles and spaces. One of the spaces is the 'managerial space' and the other is the 'practical space'.

The 'managerial space' involves managers and auxiliary administrative staff, which I have labelled as managerial function (MF), as well as lead GPs and lead nurses. My data collection in this space was through individual interface with QOF team members and through collective interactions with them in QOF meetings. Sometimes a follow up of the designated task was possible, as in the case of QOF indicators for diabetes mellitus, depression, and heart failure. Usually, these opportunities provided information for elaborating questions and reflecting them back to the members of staff at the practical level.

The 'practical space' included receptionists and clinicians (GPs and nursing teams - nurse practitioners, practice nurses, and health care assistants). One of the activities I carried out during the fieldwork in this space was shadowing clinicians' consultations. The purpose was to observe the interaction between QOF requirements (via computer software) and the clinicians. This created spaces for interviewing them, and to some extent justified my presence in the general practice environment, with an aim of experiencing practice dynamics as they reached the end of the financial year. Therefore, I had to adapt to each practice context depending on the clinicians' availability and their willingness to accept me in their

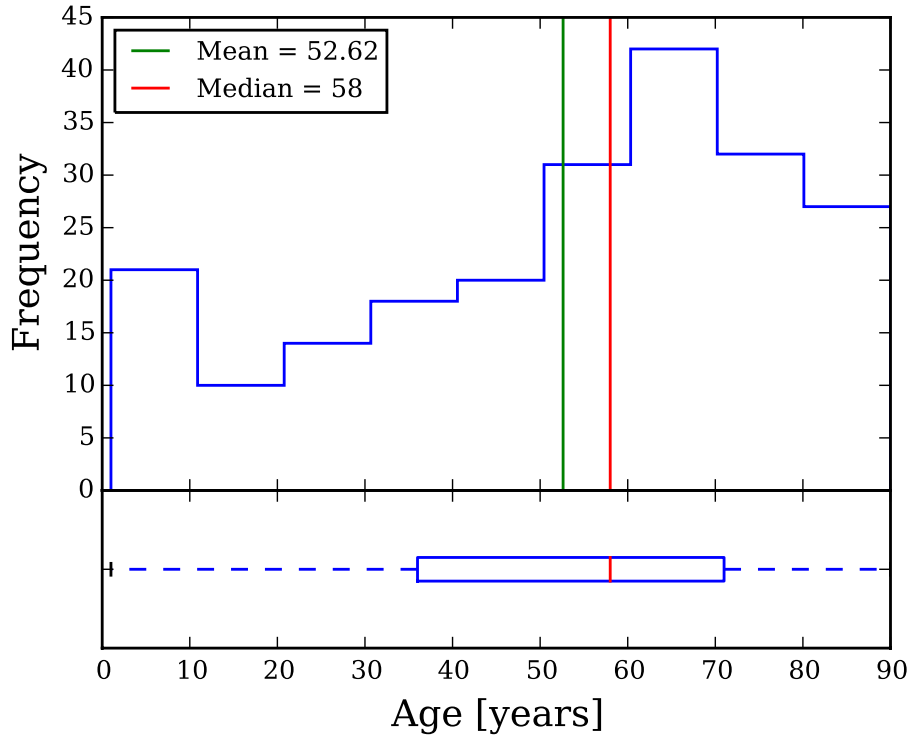
private consulting room. This produced a skewed distribution amongst the practitioners as can be seen in Graph 3.1.



	GP0.1	GP0.2	GP0.3	GP10	GP11	GP12	GP13	GP14	GP4	GP5	GP6	GP7	GP8	GP9	N2	N3
Series1	4	6	9	6	20	21	21	12	39	60	74	8	11	6	14	13
Series2	1.23%	1.85%	2.78%	1.85%	6.17%	6.48%	6.48%	3.70%	12.04%	18.52%	22.84%	2.47%	3.40%	1.85%	4.32%	4.01%

Graph 3.1. Distribution of clinical observations among different clinicians.

The time of entering practice ‘A’ was a month ahead of practice ‘B’ which affected the time spent with clinicians. As discussed further in this chapter, in practice ‘A’ I faced a different acceptance process resulting in staying initially closer to those GPs who functioned as gatekeepers, and then expanding a little as trust was built up with other staff members. In practice ‘B’ things were evenly distributed (GP11, 12 and 13), but were constrained by the time available as practices reached the end of financial year. Practice ‘B’ offered more opportunities for exploring the managerial space, reducing the time available in consultation settings. I observed a total of 326 consultations, from which 218 (67%) were carried out in practice ‘A’ and 108 (33%) in practice ‘B’. These consultations represented the primary care aging population (Graph 3.2). Females corresponded to 53% of the consulting population whereas males corresponded to the remaining 47%.



Graph 3.2. Age distribution of the population attending clinicians' consultation in both practices.

In the 'practical space' health staff were responsible for acting upon QOF requirements. The data collecting process was focused on QOF as they developed their health care activities, allowing sometimes for a quick dialogue or short interviews divided in two or three blocks. In order to summarise and organise the amount of audio-data recorded and to give it a structure, I have constructed the Table 3.3 discriminating and detailing the context of those materials allowed to be recorded according to research settings, type of activity, participants, and so on.

Table 3.3. Summary of audio-data collected according to research settings.

Participants	Code	Activity	Duration	Transcription
GPs	GP1 GP2 GP3 GP4	Focus Group	0:56:52	In full
GPs	GP5 GP6 GP7 GP8 GP9 GP10	Opportunistic interview & recoding QOF amendment	0:25:54 0:34:53 1:19:13 0:14:38 0:15:29 0:30:42	In full In full In parts In full In full

	GP11		8:00:44	
	GP12		0:22:42	
	GP13		0:21:22	
	GP14		0:12:43	
Nurse	N1	Opportunistic	0:20:31	In parts
	N2	interview	0:53:40	In parts
	N3		0:45:45	In parts
	N4		2:27:45	In parts
Managerial function	MF1	Interviews,	0:44:33	In full
	MF2	descriptive	0:45:52	In full
	MF3[#]	interviews or		
	MF4	taking part in the	1:34:12	In parts
	MF5	QOF meetings	0:58:41	In full
	MF6[#]			
	MF7[#]			
	MF8[#]			
	MF9[#]			
QOF Meeting	M1	Meeting	0:22:23	In full
	M2	interaction	1:22:08	In parts
	M3		0:58:34	In parts
	M4		1:10:48	In parts

[*]Recorded by more than one encounter. [#]Recorded as participant in QOF meetings.

PROCESS OF DATA ANALYSIS

The present ethnographic study has a purposive sampling method and its data analytical process had an iterative character, which involved the empirical evidence on the ground and my personal theoretical background. This iterative process helped me in selecting the major themes for analysis, reflected in the chapters of this thesis. The initial approach to the fieldwork was an open-ended data gathering strategy directed by a general understanding of QOF's potential unintended consequences. In this route, I sought to identify emerging potential themes by maintaining a close dialogue with the literature in order to expand and enhance the theme selection process.

Despite an open approach, my enquiry was influenced by prior study on QOF (Norman, Russell, & Macnaughton, 2014) and by the literature review required for the PhD research project and progression reporting. This has comprised several articles covering the Quality and Outcomes Framework (Appendix B). Thus, in studying QOF, various authors have addressed the potential for data manipulation or gaming embedded in this quality

scheme (Doran et al., 2008; Gravelle et al., 2008, Campbell, Hannon, & Lester, 2011; Kordowicz & Ashworth, 2011).

Additionally, the QOF biomedical model, and its connections to health commodification, was highlighted first by Harrison (2009) then by Checkland and Harrison (2011). From the anthropological stance, commodification of body parts and the links with global health bioeconomy can be found in the works of Scheper-Hughes (2001), Sharp (2000), and Cohen (2001). Furthermore, in social sciences and anthropology, Foucault's concepts of governmentality and biopower are very influential. For instance, authors such Shore and Wright (1999) and Marilyn Strathern (2000) have applied Foucault's concepts to address the rise of an audit culture in educational institutions. Hence, clearly the themes that emerged from the ground were juxtaposed against previous known content and concepts.

Thus, this ethnography resulted in an iterative process, whereby the literature and the data on the ground produced a sort of 'theme generation cycle' (Reeves et al., 2008). This process led to a refinement, narrowing the inquiry during my fieldwork on the selected theme. This meant that at some points in my fieldwork I purposefully recorded material by triangulating with different spaces, such as practice meetings, and then fed its content back to the health staff, in order to register and check what was collectively agreed during the practice meetings. The same happened when interviewing practice staff, some of my questionings were largely based on previous knowledge or on what I had previously observed. The triangulation of data collection is a well-known strategy for improving the reliability of the material gathered (Murphy et al., 1998).

Today's technological advancements allow for easily recording live-events or detailed electronic-tablet fieldnotes. This documentation associated with computer screen software images was very powerful in conveying unexplored aspects of QOF managerial scheme, since some of these materials were generated as the events unfolded, in real-time. The audio-recorded materials were transcribed in full when in the case of an interview, but this was not the case in free-recorded interactions (i.e. long clinical QOF sessions or QOF meetings). Free-recorded interactions commonly had parallel dialogues or non-QOF related themes such as conversations about a rugby match or even silence and mechanical noises due to interaction between health staff and computers. For this reason, free-recorded interactions were not transcribed in full (Table 3.3).

The activity of transcribing the recorded material, re-reading and contrasting it with other empirical evidence has strengthened the process of data analysis. I contrasted and

compared the bits of selected data to support the prioritised theme based on their 'sameness'. As Atwood, Hinds, Benoliel, and Artinian (1986, p. 138) point out 'sameness here does not mean complete identity between objects, just a sufficient similarity'. Hence, this process of data analysis refined the content or evidence to support and give meaning to the prioritised themes.

The iterative nature of this ethnography enhanced my reflectiveness, shaping the understanding of QOF managerial environment, and consequently the research results. This reflectiveness and understanding concerning the main findings was coupled by inputs from my supervisors with whom I met at regular intervals during the research period. These were important windows for discussing relevant issues, either about the fieldwork itself or for interpreting selected themes. Hence, sharing ideas and receiving ongoing feedback contributed to the interpretation and analytical data process.

REFLECTIVENESS: STRENGTHS AND WEAKNESSES

PhD anthropology research is usually a 'lone sailor' endeavour, meaning that I carried out all the interviews and observations. This might be a limitation, since other perspectives could be added in the case of a research team on the ground, allowing for expanding the site coverage, the data collection, as well as the data analysis process. Additionally, it might have permitted different interpretations of the researched object. However, the consistency of the data gathered cannot be criticised for being conducted by a single researcher. A team of researchers might just have expanded on what I found, offering further insights on top of what was obtained, but not contradicting what has been found.

Another issue that might have influenced the research data refers to my background as a Brazilian GP and the need to deal with cultural and language gaps. Although English has become an international language, it takes time for a researcher to adjust to local colloquialisms, pronunciation, accentuation, and language expressions. Despite having done my Masters in the UK and having lived in Durham for almost two years before entering the GP surgery research sites, in order to narrow the culture/language gap, I attended a regular community gathering for international students called '*Amigos*' (Friends in Portuguese and Spanish) at St Nicolas Church, in Durham city centre. This was an additional strategy to improve my listening and conversation skills by interacting with some native speakers. Furthermore, attending the GPTP throughout the research period was a key factor in

enhancing my understanding of UK general practice, its jargon, traditions, and socioeconomic and political contexts.

Additionally, to overcome any possible mistakes in data gathering, when possible, I asked permission for recording the interaction with a member of staff as a data accuracy measure. Usually practice staff welcomed this initiative as I explained the need to overcome the language gap, to improve accuracy and, therefore, facilitate my comprehension and further analysis. I found no problem in prompting the participants to re-explain things to me by simply saying that -'I have not understood this part, could you please explain it again?' about a particular topic, which usually led the participants to rephrase and be more explicit about the theme being discussed. This will be exemplified in some of the quotations used in the thesis.

The peculiarity of the data gathering process might reflect my medical background (Norman & Tesser, 2015). This gave me an 'insider' status in terms of being seen as a general practitioner and allowing me access for privileged information that a non-physician researcher might have struggled to obtain (Checkland, 2004). I reinforced this status by informing everyone that I was attending the GPTP. However, being 'outsider' of UK general practice and its managerial context gave me a genuinely naive profile boosted by my Brazilian English accent. This, I surmise, might have created a less threatening identity and reduced some of the resistance I as a researcher could otherwise have faced.

Despite being a GP, I could not work as a physician in the UK as it would require a medical certificate validation process. Having the possibility to work as a GP might have rendered, I believe, a different perspective by embodying the experience of being under the QOF working scheme environment. Nevertheless, some aspects of GPs' practice and atmosphere were preserved as I shadowed GPs and nurses in their consultations. This showed me the surgery's organisation, the interactions between health staff and computers, and the population profile, helping to contextualise the data analysis process by putting things into perspective. All members of health staff seemed to be really committed to providing the best care to their patients.

ETHICAL REQUIREMENTS AND CONSIDERATIONS

This research was granted approval by Durham University Department of Anthropology Research Ethics and Data Protection Committee on 25th January 2013 (Appendix C). Despite general practice being under the NHS Health Research Authority, this research project was not considered to require a full review by an NHS Research Ethics Committee (REC). The Advisor's comments (REF 04/26/57, Appendix D) can be summarised as:

- I would deem this a service evaluation and hence does not need REC review.
- The research will continue to require management permission from the host care organisations ("R&D approval").
- All types of study involving human participants should, however, be conducted in accordance with basic ethical principles, such as informed consent and respect for the confidentiality of participants. In addition, in processing identifiable data there are legal requirements under the Data Protection Act 2000.
- This response should not be interpreted as giving a form of ethical approval or any endorsement to your project, but it may be provided to a journal or other body as evidence that ethical approval is not a requirement.

The main reason for not needing a full REC review was that the research did not directly involve patients as main research subjects. I was, however, interacting with them indirectly while conducting the research. The Primary Care Trust (PCT) research authority understood the research almost as an audit aiming to understand the QOF managerial effect on health staff. The PCT approved the research clinical governance on 13th February 2013 (Appendix E).

When designing research projects, any major distress that might be caused by ethnographic study is difficult to anticipate; however, as time went by, the object of my research ended up revealing itself as a highly sensitive subject, which inevitably will be reflected in how this thesis is written. As stated by the Association of Social Anthropologists (ASA) of the UK and the Commonwealth (2011, p. 1):

> Anthropologists, like other social researchers, are faced increasingly with competing duties, obligations and conflicts of interest, with the need to make implicit or explicit choices

> between their own values and between the interests of different individuals and groups. Ethical and legal dilemmas occur at all stages of research.

Both practices collectively had agreed to allow me into their surgeries to carry out an ethnographic study. This never resulted in any written consent, since PCT clinical governance approval was considered to be enough. In this case, GPs and other members of staff were well aware that I was conducting this research, being themselves the main participants and the focus of the research. This scenario is different from those highlighted by the ASA (2011, p. 2):

> In some cases, consent will initially need to be sought from individual gatekeepers such as community leaders and officials: chiefs, local councillors, headmen, hospital consultants, trade union leaders, etc. or from *collective decision-making bodies* such as community or neighbourhood assemblies. In addition to needing to negotiate access to the field through such "gatekeepers", it will often be desirable to supplement the informed consent of collective bodies with that of individuals, particularly *where substantial sectors of the local society are excluded from collective decision-making* [emphasis added] but are also subjects of the research.

In both GP surgeries, those attending the collective decision-making process were powerful people, though with different power position in regards to their function and type of contractual arrangements. These members of staff attending the practice meeting were the main participants of my research project. Thus, the strategy adopted in the research was to seek both collective and individual agreement based on mutually respected oral consent. For instance, this ethnography sought to capture people's interactions in 'real-time' and management meetings, which used to fluctuate in time schedule and number of participants. Sometimes there was an opportunistic event, as in the case of a QOF meeting that occurred in the middle of a GP session, when I happened to be there and asked permission to record it. The same approach was used when, during fieldwork, a 'research window' appeared in a clinical session to interview a member of professional staff or to record a work activity. The same consent procedure was equally applied when taking pictures or video recordings of technical material related to QOF.

However, when the interview was planned ahead or was conducted outside the practice, as in a focus group carried out at the GPTP, written consent was obtained from the participants. This research was primarily interested in observing how QOF, as a biomedical

technology, influences general practice and how the monetary factor embedded in QOF standard requirements affects general practice dynamics throughout the financial year. To some extent, this approach helped to protect the individual participants.

One main operational and ethical issue in studying health related technologies is engaging with vulnerable people or those in disadvantaged power positions, such as patients (ASA, 2011). In reality, where patients were concerned, this was not the case, since each surgery as training practice had been dealing with this matter before, although individual practice approaches differed. For instance, in practice 'A' receptionists asked patients' consent to allow me to be in the consultation room when they arrived at the reception and marked 'yes' or 'no' into the patient appointment slot. Doctors or nurses could then see if the patients had agreed with my presence in the consultation before calling them in. This surgery characteristic of training practice can be read on practice's webpage (Figure 3.2).

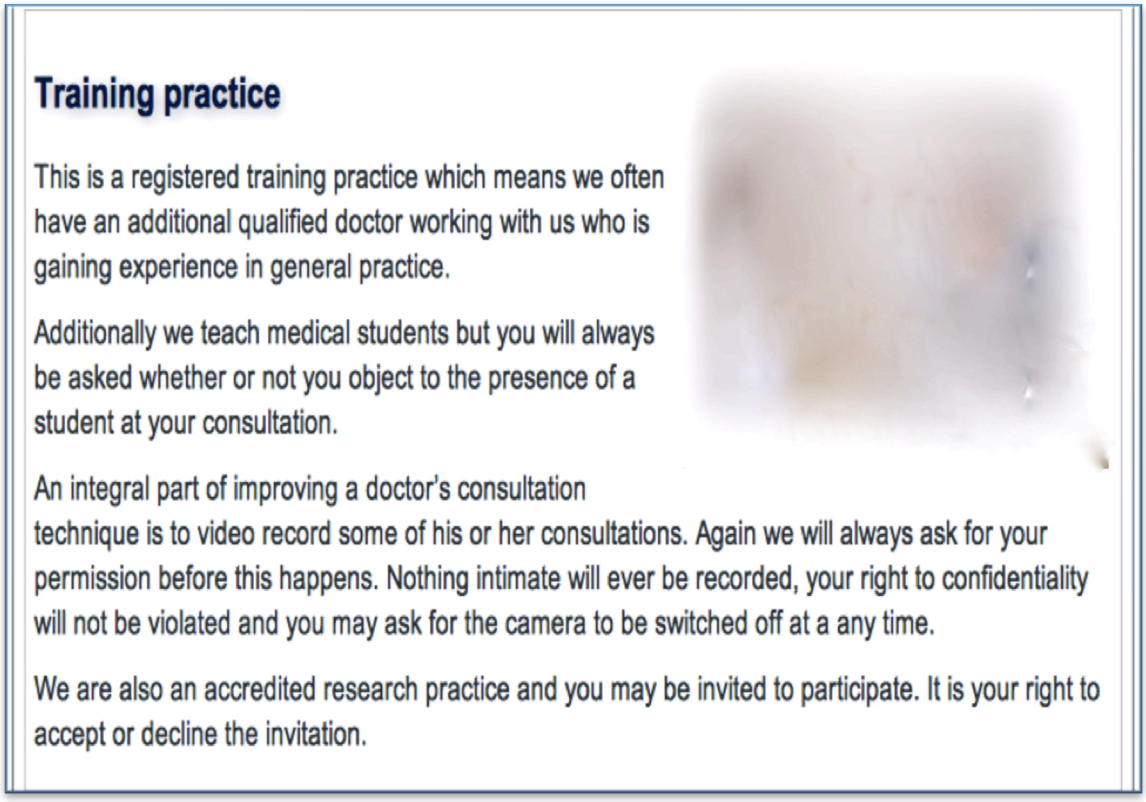


Figure 3.2. Practice 'A' training ethical policy.

In practice 'B' the professionals themselves asked the patients directly when they had arrived at the doctors' room if it was 'OK' for me to stay in the consultation. From an ethical

perspective, practice ‘A’s procedure was better, since it allowed a protective space for patients to decide whether or not they would prefer my presence in the consultation. In both cases, I was introduced as a ‘Brazilian doctor’ who was studying the ‘NHS’ or who was studying ‘how we do things here, in the UK’.

It seemed to me that patients were used to both procedures and did not feel uncomfortable with my presence and this, to some extent, allowed for a good interaction with me. This may be due to the fact that both GP surgeries were training practices and patients were already exposed to people under training schemes, either observing or participating in patients’ care plans. In few cases I was informed that the patients did not want my presence such as when mental health issues were involved, and in one case of a pregnancy termination. Sometimes, I decided that would be better for me to leave the consulting room due to the nature of the patient’s complaint or physical examination. Since the focus of my research did not aim to analyse in-depth doctor-patient relationships, no recording of these moments were made and, consequently, no additional ethical requirements were necessary.

Being introduced in both surgeries as a ‘Brazilian GP’ studying the QOF scheme and not as an anthropologist might have given me access to contexts and subjects that outsider researchers would have had more difficulties in reaching. Moreover, my personal knowledge of medicine and familiarity with Brazilian and UK GPs’ culture reduced some barriers, facilitating a more candid discussion around QOF. This presented me with an ethical dilemma: how to describe this fieldwork endeavour without exposing the practice groups and professionals to unforeseen consequences, since both participants and institutions had generously decided to harbour this research project?

Thus, to secure confidentiality and anonymity and, at the same time, to give voice to the material collected, the strategy adopted in this thesis necessarily resulted in minimising the chances of tracing back both subjects and medical groups involved in this ethnography. This request was made very clear to me when I presented my research project in practice ‘B’ meeting and received the collective permission by the practice team to conduct my research in their premises. In this regard, I have decided to not situate regionally the research sites in the UK, as well as to link any of my participants recorded extracts to their working place, function or hierarchical position in both medical groups. For this reason, I (AHN) decided to label financial or practice managers, and equally their auxiliary staff, as ‘Managerial

Function' (MF); lead nurse practitioners as 'Nurse' (N); and lead GPs as 'GP', and so on, in order to protect their identities (Table 3.3).

OPENING THE ETHNOGRAPHIC ACCOUNT

What follows briefly describes the initial phase of fieldwork and the challenge of being accepted until its expansion to include the second medical group. The aim is to give a flavour of this initial phase in conducting an ethnographic study in the UK general practice, as well as to put into perspective the major selected themes addressed in this thesis.

Induction phase in general practice: being accepted

The process of being accepted in the GP surgeries was very different between the two practice groups. In the partnership model the acceptance occurred through various approximation steps: (a) email exchanges with different actors (GP partners and managers); (b) invitation to attend a local Clinical Commissioning Group (CCG) meeting to exchange successful experiences in referral strategies; (c) invitation to attend a lunch meeting related to QOF training; and finally (d) introduction to the practice team by an index GP in one of the training lunch meetings. Nevertheless, being introduced to the practice team did not mean that I was authorised to start my fieldwork. It took another couple of emails to set the specific starting date.

This relatively long process of being accepted produced an implicit collective agreement, with no requirement of showing the research project to the practice group, probably because some of the partners already attended my 10-minute presentation at the GPTP. This resulted in gradual assimilation about what my research entailed for the overall practice team. For instance, in the beginning the managers thought that my research would last only two weeks. I was asked several times by different members of staff; - 'How long have you planned to do your research?' The idea of longer-term fieldwork took some time for the staff to accept or understand. For example, when I was reaching the end of my first-two weeks in the surgery 'A', the branch manager asked me if this was my last week. Then, I had to explain again that these two weeks were for me to get a sense of the GP surgery backstage and management style, and that the next step would be to shadow some GPs' consultations, if possible. However, the branch manager did not seem comfortable with that, since, this would

imply adding more challenge to the already busy practice routine. The branch manager started to look at the staff grid searching for some doctor, then suddenly realised that the doctors would be having lunch together. I was then advised to go with them and speak about 'shadowing doctors' consultation rooms' and ask them if they would be happy with that.

It seemed that the message at the beginning of my fieldwork was not clear (or was not shared properly amongst the partners and other members of staff), despite having sent all research project information and even its summary in a PowerPoint file to facilitate the understanding of what my research project entailed. Thus, being accepted in practice 'A' was a gradual and ongoing process. On the other hand, in the 'company model' (practice 'B'), despite taking longer to get the first contact with a practice team member, being received in the morning practice meeting with all main staff and having the chance to explain to the whole group about my research project led to a better understanding and a collective acceptance by the practice team, which facilitated my circulation within different practice spaces.

In both sites, a member of administrative staff (usually a manager, but sometimes a supervisor) organised my activities in the practice and helped me to get into the GPs' or nursing consultations and/or any QOF-tasks such as QOF meetings, staff training meetings and regular meetings. My schedules were organised weekly to allow for some flexibility in case something new happened.

Hence, in order to be fully accepted and to optimise the available time, I tried to develop a closer relationship with those more involved with QOF activities: the leads (i.e. lead QOF administrative, lead GPs, lead nurses, and lead managers) to secure a key source of information for understanding the QOF phenomenon.

Being equipped to navigate in the UK general practice

On 4th November 2013 I arrived in the first practice setting (practice 'A') at 9 a.m. and waited in the reception area for the practice manager. Then, after couple of minutes the practice manager came and took me to a room, which looked more like a storeroom (with books and old documents organised in shelves, a computer and some chairs) but in fact, it was a space usually used for study by registrars and trainers. We then exchanged some

information and I took the chance to explain the research project again and that my intention was to stay until the end of QOF financial year.

After this preliminary phase I told the manager that the aim of my research was to explore other spaces and to observe GPs' and nurses' consultations, and how they deal with QOF on daily basis. There was no questioning to my statement, which was followed by an explanation about the surgery organisation, the practice organogram, and number of staff involved in the practice medical group. The initial agreement was that during the first week of my fieldwork I would rotate among the reception, administration and manager activities. I was then introduced to the branch manager who became responsible for organising my activities in this medical group.

Figure 3.3 shows the number of people involved in the first surgery setting and the size of the practice group. Some of the administrative staff and receptionists, as well as some of the nursing staff work as part-timers. In terms of gender, women predominate in general practice but gender was relatively balanced amongst the doctors in practice 'A'.

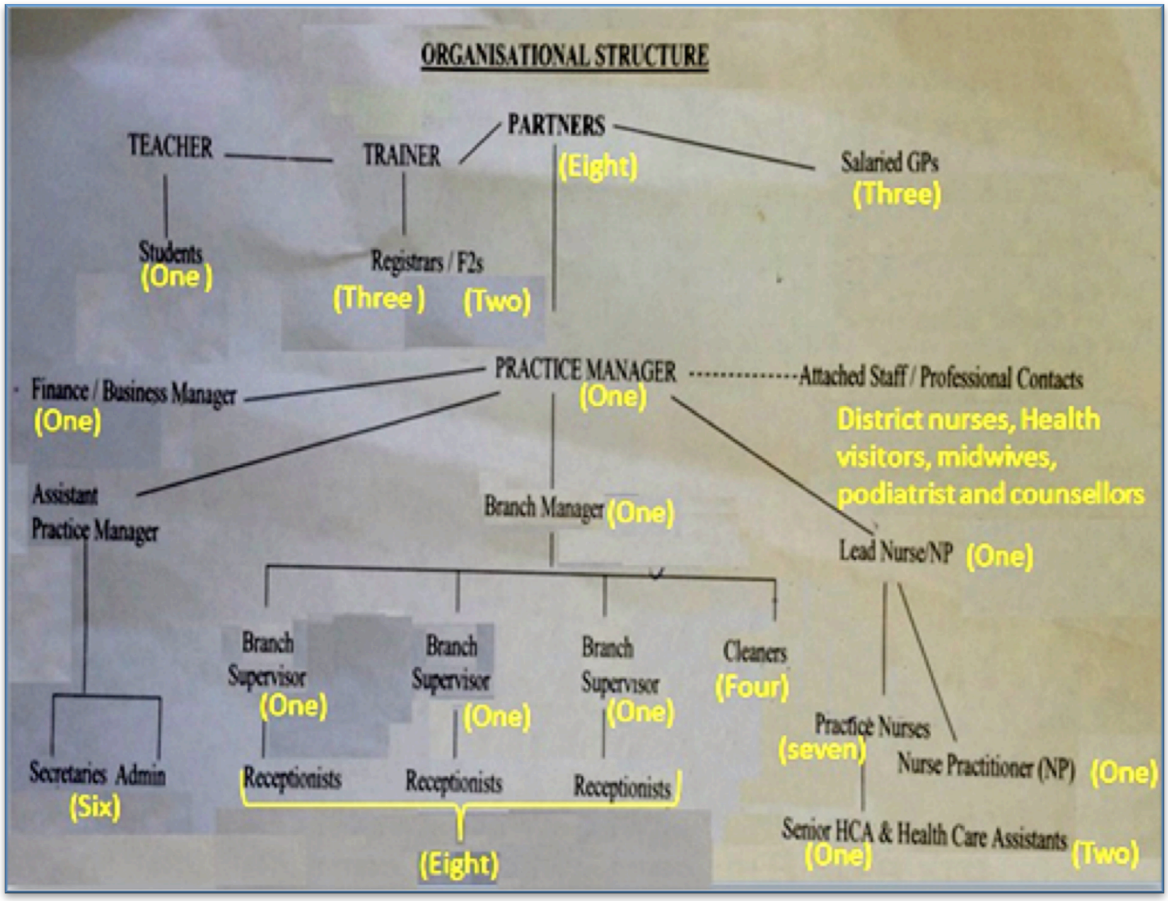


Figure 3.3. Practice 'A' organogram.

The implicit strategy was to become a familiar figure among the staff and to understand the backstage of general practice business. For instance, staying with the receptionists provided the space for seeing flows of patients and information, how patients were scheduled and how they accessed the clinicians. The reception was an informal meeting space, which allowed for casual conversations among the staff. Additionally, the receptionists explained their role, the practice routine, as well as doctors/nurses' appointment arrangements.

Staying with the administrative staff allowed me to understand the flow of information and their involvement with QOF, such as preparing letters to invite patients to come to the surgery for particular QOF targets. Moreover, they control what comes into the practice in terms of letters from other levels of care such as hospitals and consultants and information or documents that are sent such as referral letters to other care units. These documents or letters are usually scanned and added to patients' records.

Then, I had a quick training with the information technology system (IT) expert and financial manager assistant on the basic default and settings of System One software package used by the surgery. I was then explained their role in monitoring QOF indicators and putting QOF alerts into patients' appointment slots to help doctors and nurses in their QOF tasks (further discussed in Chapter Four). Apart from being the platform for patients' records, this software permits the management of QOF work and any information update. This administrative member of staff has a key role in tracing and fixing QOF code issues and carrying out audits in regard to professional performance.

In the first week of my fieldwork in practice 'A', I had an opportunity to talk to the practice financial manager who explained to me the role of a financial manager in regard to QOF and its importance to the practice incomes. This induction phase helped me to acquire the basic background framework required to navigate into general practice, preparing me for the second phase: to observe GPs' and nurses' activities and to attend QOF team practice and training meetings. This initial phase saved me time because the moment I started the fieldwork at the second surgery, on 5th December 2013, I already had the basic knowledge to circulate within general practice since both settings used the same software (System one) for managing their QOF affairs.

CONCLUSION

This chapter described and presented the methodological approach I took to address QOF as a biomedical technology and its effects on general practice in the UK. In the following chapter the ethnography becomes thematically framed as it focuses on QOF as biomedical technology and some of its influence in the working processes of general practice.

Chapter Four

GOVERNMENTALITY AND QOF: A CASE STUDY

This chapter addresses the Quality and Outcomes Framework as a clinical governance strategy set up to improve general practice in the UK. As an analytical tool, Foucault's concept of governmentality is used to shed light on this apparently neutral biomedical technology. Governmentality, the art of government or the rationality of government, became historically distinct when the population was placed at the centre of the state's economy. According to Foucault (1991a, pp. 99-100), from the mid-eighteenth century onwards a move occurred from a family-economic perspective into a population-economic perspective, a process whereby the 'family appears in this dimension of instrumentality relative to the population, with the institution of campaigns to reduce mortality and to promote marriages, vaccinations, etc'.

Population health has been one of the main activities pertaining to the art of government. In the UK, the National Health Service is a 'governmental body' in charge of monitoring and improving the population health standards within a welfare state. In the NHS, GPs represent 50% of its medical workforce covering all the UK population (Roland, 2004). I propose that the introduction of QOF in the 2004 GMS contract typifies the rationality of government: 'the management of population in its depths and its details' (Foucault, 1991a, p. 102).

In the book *Discipline and Punish: The Birth of the Prison* Foucault describes the integration of two approaches to population health: the 'leper' and the 'plague' strategies. The former was based on an exclusion process, since it was possible to identify the infected persons by the disease's stigma and isolate them from the rest of society. The latter needed a new approach since the plague was an invisible threat, lurking in towns, devastating whole cities and communities. This situation made the leper's binary approach essentially ineffective. A different strategy was therefore developed to deal with the plague, one that needed at the same time to be individualising and totalising. Foucault (1977, p. 196) describes the plague strategy as a system of 'permanent registration'. This comprised of a hierarchical surveillance framework. At the bottom, the syndic would do the daily 'roll calls' during the 'lock up' time observing in the household any signs of potential disease threats or irregularities, and then reporting them to the town quarter intendants. The intendant would

keep the record of his population catchment area profile and health conditions. This information would, then, be sent to the magistrate or mayor at the top of this hierarchical monitoring system who would be responsible for running it:

> The magistrates have complete control over medical treatment; they have appointed a physician in charge; no other practitioner may treat, no apothecary prepare medicine, no confessor visit a sick person without having received from him a written note "to prevent anyone from concealing and dealing with those sick of the contagion, unknown to the magistrates". The registration of the pathological must be constantly centralised. (Foucault, 1977, p. 196)

Foucault remarks that the leper model and plague model would be eventually integrated into a more efficient, powerful disciplinary system called the Panopticon. Bentham's Panopticon prison model encapsulates both of these approaches, since it applies the sophisticated disciplinary mechanism to those secluded in the prisons. Additionally, his model could easily be expanded to other institutions such as schools, factories and hospitals. Controlling and managing the population became a vital enterprise in the art of government: the biopolitics.

This chapter follows Foucault's approach by asking *how* QOF works as a biomedical technology, that is to say, its 'regime of practices' (Foucault, 1991b, p. 75). To better understand the GP's clinical governance environment, the practice of QOF can be roughly divided into two components: the management of QOF and the practice of QOF. The managerial space encompasses administrative staff, managers, and lead QOF GPs/nurses whose main role is surveying, controlling, and monitoring how QOF targets are progressing during the financial year, and ultimately prompting staff to do QOF 'stuff'. This pushing of health staff to do more can be framed as 'the stick exercise'. The practical space refers to receptionists and clinicians (GPs and nursing teams - nurse practitioners, practice nurses, and health care assistants). In the frontline, interacting more actively with patients and fulfilling QOF requirements, receptionists and clinicians perform the 'tick box exercise' (Heath, 2007).

QOF's MANAGERIAL SPACE

I have documented the QOF's managerial space by firstly recording conversations, explanations, and demonstrations of how QOF works either by those staff in managerial functions or by attending QOF team meetings as they went through the daily managerial aspects of general practice. Secondly, I interviewed selected members of staff of the QOF

managerial team in order to clarify specific points in regard to QOF; and finally, I attended a GP training scheme module on practice management, delivered by three managers, covering both the financial and practical management aspects of GPs' surgeries. This route helped me in constructing a better picture of general practice management in relation to QOF: a 'system of permanent registration' (Foucault, 1977, p. 196).

IT system: a central piece in practice management

Central to the QOF scheme is the IT system, which allows the managerial staff to monitor both QOF progression and health staff activities. As computer software programmes organise the QOF's rules in a practical fashion, specific explanations concerning its operationality are necessary. Other complementary features of the IT system are presented as the chapter progresses. Both GP practices were using 'System-one' software package.

As explained in Chapter Two, QOF operates within audit logic by setting clinical criteria (indicators) against a set of standards (level of achievement for a particular indicator). This was recognised by one of the GPs when asked about how QOF could be defined:

> *'It's quality assurance delivered by a series of… clinical audits...*[it] *is the way I would define most of QOF, certainly the clinical part of QOF'.* [GP1]

Thus, QOF operates in a range of achievement levels that can be roughly divided into three bands: below the target threshold, within the target threshold and above the target threshold. This information is organised by System-one software in colours, respectively: red, orange, and green. Moreover, the computer software displays practices' overall level of QOF achievement in two ways: current level of achievement (i.e. 'How Am I Driving') and the projected level of achievement (i.e. 'End of [financial] year'). Figure 4.1 explains these QOF sub-headings and colour default in the software package. It highlights the careful use of words to give agency to practice teams: 'How Am I Driving'. This gives practice staff a feeling of being in control over their own activities by concealing the fact that they are being externally driven and not completely 'driving' their professional tasks.

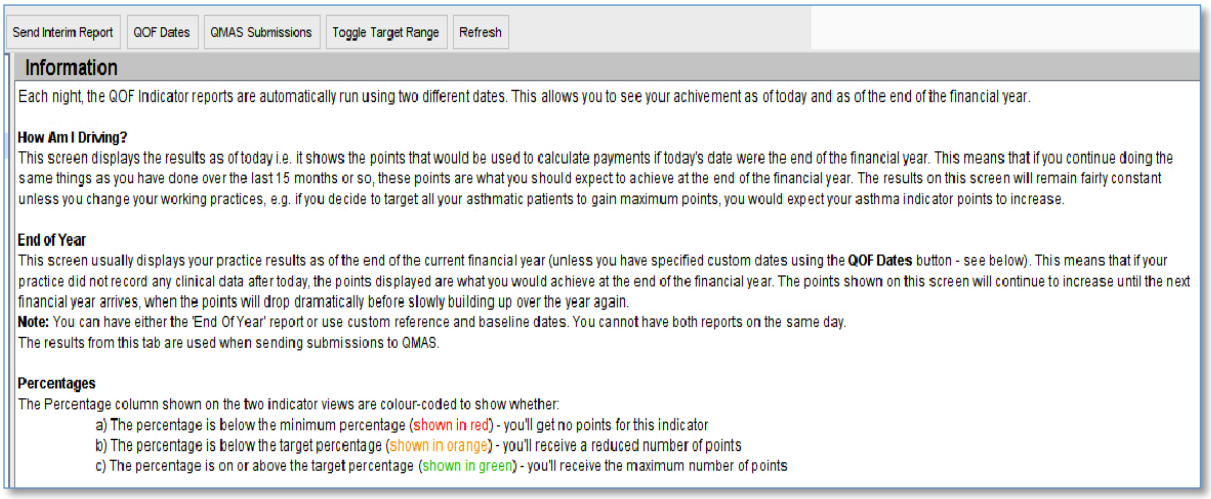


Figure 4.1. How Am I driving, end of year and percentage of achievement organised by colour.

The computers' programme automatically organises QOF criteria in relation to the practice's registered patients and QOF disease targets in a summary spreadsheet with the heading 'QOF indicators' (Figure 4.2). This summary spreadsheet allows the management of the practice's population catchment area.

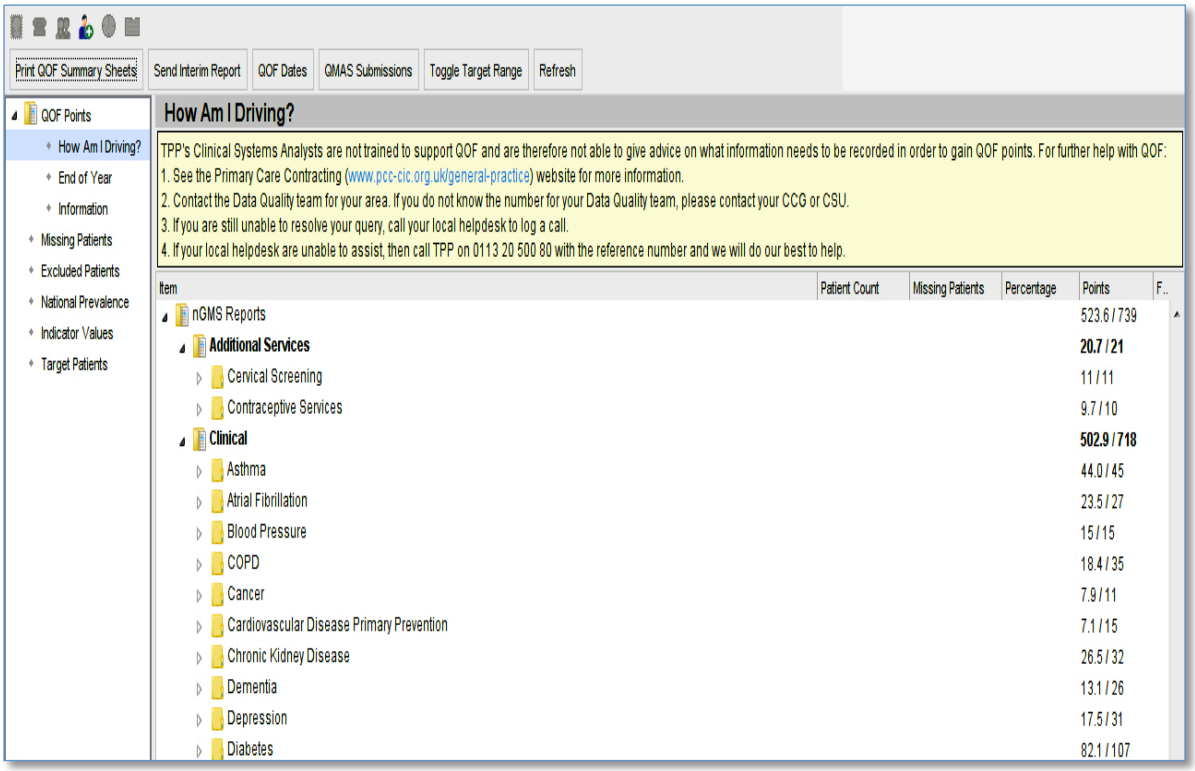


Figure 4.2. Part of QOF summary spreadsheet showing additional services, clinical indicators and main headings on left-hand side (How Am I Driving, End of Year, Information, Missing Patients, Excluded Patients, National Prevalence, Indicator Values and Target Patients).

Figure 4.2 shows part of 'QOF indicator' summary spreadsheet with the most important 'headings'. By a mouse right-click action it is possible to produce a list of patients for each QOF target. It provides important additional information such as 'missing patients', 'excluded patients', 'indicator value' and 'target patients'. The latter refers to those patients who are worth more financially to the practice.

Each of the above clinical target files (asthma, atrial fibrillation, blood pressure, etc.) can be expanded to expose in detail the sub-indicator requirements for every QOF clinical domain, as described in Chapter Two. The 'QOF indicator' summary spreadsheet gives a picture of the whole QOF, allowing for narrowing down to each individual patient linked to a particular QOF sub-indicator. That is, by doing a mouse right-click action in any of QOF sub-indicator, a member of staff can generate a list of patients organised by number of QOF points or monetary value (Chapter Five, p. 111).

Figure 4.3 illustrates the diabetes clinical indicator requirements. This has the greatest number of clinical sub-indicator targets highlighting the detailed characteristic of QOF's disease management.

Item	Patient Count	Missing Patients	Percentage	Points
Diabetes				29.5 / 107
DM001 - Diabetes Register	809			6 / 6
DM002 - Last BP is 150/90 or less	545 / 800	255	68.1 %	3.0 / 8
DM003 - Last BP is 140/80 or less	463 / 798	335	58.0 %	5.0 / 10
DM004 - Total cholesterol < 5mmol/l	401 / 775	374	51.7 %	2.0 / 6
DM005 - Micro-albuminuria testing	400 / 807	407	49.5 %	0 / 3
DM006 - Proteinuria or micro-albuminuria	73 / 96	23	76.0 %	1.4 / 3
DM007 - Patient has IFCC-HbA1c <59mmol/mol	330 / 791	461	41.7 %	2.9 / 17
DM008 - Patient has IFCC-HbA1c <64mmol/mol	379 / 794	415	47.7 %	0.9 / 8
DM009 - Patient has IFCC-HbA1c <75 mmol/mol	441 / 796	355	55.4 %	0.9 / 10
DM010 - Influenza immunisation	491 / 771	280	63.6 %	0.7 / 3
DM011 - Retinal screening	414 / 775	361	53.4 %	0.4 / 5
DM012 - Foot examination in last 12 months	422 / 804	382	52.4 %	0.2 / 4
DM013 - Dietary review in last 12 months	187 / 804	617	23.2 %	0 / 3

Figure 4.3. QOF diabetes sub-indicators and four columns: Patient Count, Missing Patients, Percentage (by colour) and Points Achieved.

At the individual patient level, System-One has a particular computer default called the 'QOF timeline'. This timeline helps both managers and health staff to see which of QOF sub-

indicators needs to be acted upon. Its comprehension is facilitated via a visual sub-indicator colour classification system: green, red and grey. Green means that the sub-indicator was achieved; red that it was not achieved, therefore needing to be acted upon; and grey means that the patient was excluded from that particular sub-indicator. At the bottom of the QOF timeline sits the financial calendar year (Figure 4.4).

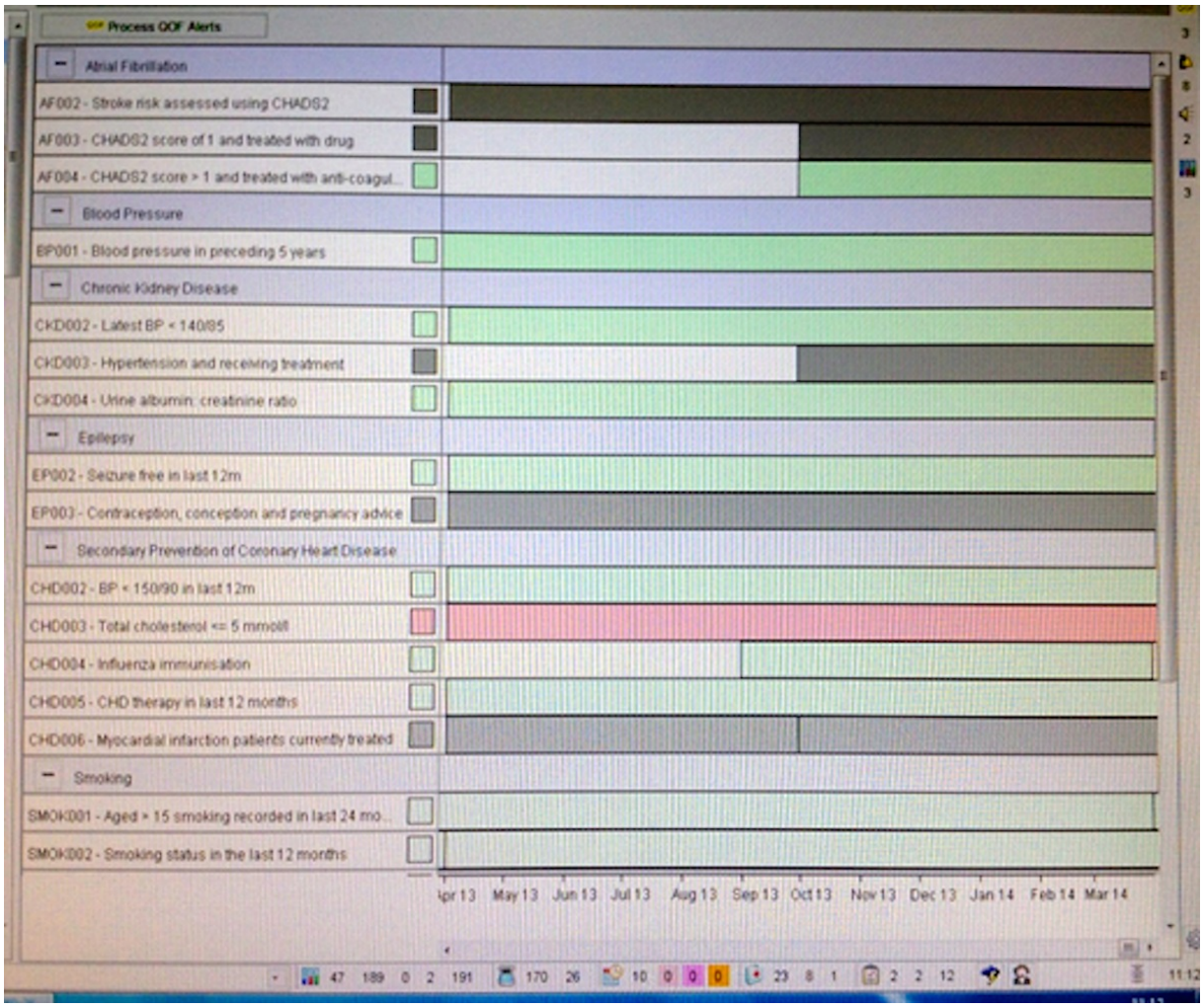


Figure 4.4. QOF timeline: sub-indicators classified by colour according to QOF indicator achievement status.

The QOF timeline gives the members of health staff a sense of the time left for them to act on each of the sub-indicators. Thus, as time goes by the pressure on staff to concentrate on 'QOF stuff' becomes greater. The computer programme importantly helps the managerial team to trace QOF requirements and has become an indispensable tool in the everyday activities of managerial staff.

QOF team: a managerial surveillance strategy

Management is a key structure for running GP surgeries and can be divided into finance management and practice management. The former controls the budget and tries to maximise practice incomes/profits. The latter deals roughly with the everyday business of running a practice: ranging from human resources and management to the practice maintenance in accordance to Care Quality Commission (CQC) requirements. Small practices might have different arrangements, such as concentrating both functions just in one manager or other alternative ways.

Management is fundamental for ensuring that QOF requirements are being met as the financial year progresses. When I enquired a member of managerial practice team about the practice manager's role, the answer was as follows:

> *'It's quite a difficult one to put into words, how to explain…hmm…it's sort of being the…hmm… it's sort of the central person to keep all the teams running right. Yes, we have, you know…I'm one person, but I also have close working relations with the lead nurses, lead GPs, so I don't just manage it all, you know, myself…it involves other leads, we've been such a big team here. We have to look at the organisation issues, making sure that the appointments are there…hmm…looking at procedures, policies…hmm…looking at things like QOF, managing the team who looks after QOF, we also have enhanced services and prescribing incentive schemes, so there's a lot that goes on, on the top of just day-to-day management. I also have to look after health and safety…hmm…building maintenance, infection control…hmm…so, there's a lot more than <u>just</u> the organisation…'* [MF5]

Despite the function division into finance and practice management, both managers are involved in helping the practice to achieve QOF indicators by '*looking at things like QOF, and managing the team who looks after QOF'*.

Both practices had a QOF team that was more concerned with keeping track of QOF requirements. In practice 'A' they were three main staff, whereas in practice 'B' six people were more directly involved within QOF management. QOF teams usually comprise GPs, nurses, administrative staff and managers. Commonly, they are involved in specific tasks, as reported below:

> *'My involvement with QOF…starts…in various ways because I get involved in Flu campaign…so I'm responsible for the Flu campaign. Now…there are four QOF indicators that relate to…flu immunization.* […] *So, using System-One* [referring to the software] *we…I*

use 'the QOF indicators'…here [showing on the computer screen]*…and I always go to the "end of the year"* [on the computer screen], *because that's where we need to be, we need to be working on the 'end of the year'* […]. *For example, in the COPD* [Figure 4.5] *it tells us…how many patients we've done…315 against how many patients are in our list to be done…418, tells us our missing and tells us our achievements. The government target for achievement is 75%, so we are at 75% on the COPD already…hmm…but we need obviously… to push up because at the moment…if say, we did no more on these patients we only earn 2.8 QOF points out of 6…(.hhh)…*[…]*…we are sort of heading in the right direction, so…not quite half yet…(.hh)…so we still have…what QOF is telling…hmm…what System-One is telling* [us] *is that there're still 103 patients to be seen'.* [MF2]

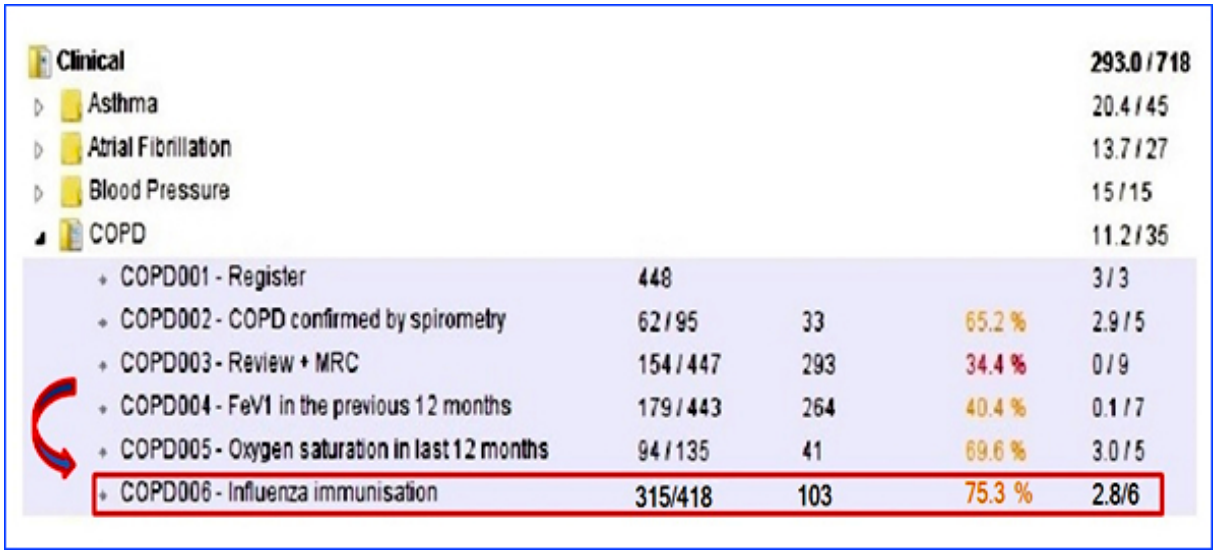


Figure 4.5. Level of achievement on flu vaccination for COPD patients. COPD: Chronic Obstructive Pulmonary Disease.

As exemplified above, assigning a particular QOF indicator to each of the QOF team member is one of the strategies adopted to secure QOF achievement, as in the case of flu vaccination linked to four chronic diseases such as diabetes, coronary heart disease, COPD, and stroke: '*I get involved in flu campaign, so I'm responsible for the flu campaign'*. This leading role helps with the QOF chasing strategy: '*What System-One is telling is that there're still 103 patients to be seen'*.

Another QOF characteristic is the 'authority' that it has assumed, interacting actively by 'telling' the practice staff that there are still 'missing patients'. This system bears similarities with the plague model. The 'Magistrate' role (i.e. the Department of Health) is materialised through 'System-one' constant requests for information in order to measure general practices' clinical 'quality' standards and, then, to reimburse them. Hence,

monitoring specific 'missing patients' has become an integral part of the QOF scheme via the 'intendants' (managerial staff) and the 'syndics' (health practice teams) for controlling population. Regularly, lists of patients are produced to invite them to come to GP surgeries for QOF interventions and reviews.

> *'But, all of these codes here in the records…all of the information that is gathered and coded…comes towards what this system is looking for to satisfy the criteria…and those values.* […]*…So, regularly we would print off...hmm…reports in relation to the missing data* [missing patients], *so, I'll show you the…I'll show you the missing patients, we can break it down into branches so, we can send lists to each of the branches, and they* [receptionists] *could ring them and invite patients in to come and have…the review that is needed'.* [MF1]

One aspect of the QOF managerial framework is to do external or practice's catchment area surveillances, resulting in inviting '*patients in to come and have the review that is needed*'. The close resemblance to the 'plague approach' is obvious:

> Every day, too, the syndic goes into the street for which he is responsible; stops before each house: gets all the inhabitants to appear at the windows (those who live overlooking the courtyard will be allocated a window looking onto the street at which no one but they may show themselves); *he calls each of them by name; informs himself as to the state of each and everyone of them* [emphasis added]. (Foucault, 1977, p. 196)

Another aspect of management activities is internally oriented, to track and monitor staff activities, as well as optimising the spaces available, bringing 'target patients' in for QOF reviews:

> *'So, that sort of basically, what I do with QOF, it's just keep tracking up…and, periodically I flick around the screens and think: -"Oh! Such and such isn't busy this afternoon". I'll then speak to* [branch supervisor], *if she's around or what else or I'll just speak to the receptionist and say: - "Look, I've noticed that such and such doesn't have many appointments booked this afternoon. Can we please try and tackle* [some missing patients or targets]*?" And then send them away with a particular subject* [a target patient list], *depending on…where we are, what time of the year it is'.* [MF2]

This internal monitoring process - surveying clinicians and receptionist activities in regard to QOF – has turned into a common task for managers and/or their auxiliary administrative staff

in order to increase the chances of achieving QOF targets. Boosted by an efficient IT system, which allows real-time practices of verification (Power, 1997), clinicians' attitude towards QOF is monitored in order to increase their compliance.

> *'I'll just pick a few screens just to show you…these are some of the nurses' screen, but (have to do with?) doctors as well, so…what I did, I hover…over…and if it* [the computer] *says "has QOF alerts", I then open the patient's record…(.hh)…hmm…so if I've just opened that one…this was what I was doing yesterday…just hovering over and seeing…and he's got loads and loads of QOF outstanding, but he's coming in to see the nurse for something else…(.hh)…so,* [I] *double check on…the* [QOF] *timeline and all of the reds and things we need to try to do to him…but what I have…I have done…is that…*[looking at the patients record and realising]*…he's…been in…it's finished?...yes…he's been in…to see…hmm…the nurse, so what I've put on was…he was coming for COPD…anyway, that's was already in there* [the prompts in the patient's record], *and I put* [in patient's appointment slot]*: "- Please offer Flu vaccination"… just to try and give them a prompt as something else to do…'* [MF2]

Prompting health staff to do the QOF-tasks – the stick exercise – has become one of the major activities of managers and their auxiliary staff as they '*try and give them a prompt as something else to do'*. The rationale behind this was explained to the GP trainees on a module about practice management. The financial manager in the GP training scheme explained to GP trainees the importance of *'adding an alert note on patients' appointment slot'*, despite having QOF requirements already displayed in the front page of patient's records, in red or as QOF timeline. He told us clearly: -*'Because there is a practice manager looking at it'*. In other words, doctors and nurses know that the managerial staff are looking at them and it would therefore be possible for them to *'name and shame'*, if this was the case, i.e. for those who were not responding to the dictates of QOF in a firmly or opportunistic fashion. This resonates with Foucault's panopticist regime, a process whereby health staff 'knowing that their actions are in principle observable (if not always actually observed) become the bearers of their own surveillance' (Harrison, 2002, p. 475). In practice, however, this attitude is perceived more as an extra help or 'just a reminder' for them to act upon QOF indicators:

> *'…We don't need to put these things on* [referring to the alerts or prompts], *but it kind of helps them out, if we've got time, which…sometimes we haven't…we can't…hmm…indicate to them what they're coming in for, because…that person won't necessarily be coming in…for…the BP* [blood pressure], *they might be coming for their INR* [anticoagulation control], *and*

somebody might miss to do their BP and smoking even though it's on their home screen…for them to see…they just get embroiled in a conversation, when the patient comes in and…the job in hand and rather than...so these…some of these people come in quite regular, but we still miss…their blood pressure and their smoking…and it's just the case when they come in, just say: - "Mrs. XX, I'll take your blood pressure while you're here" and you know..."can we update your smoking status?" And it all takes time…and we are under pressure...[…]*...It's a prompt to indicate to you that…"this patient needs this".* [MF1]

The above utterance refers to an extra reminder intentionally selected by the managerial staff that is added into a patient's appointment slot, even though the patients' front-page screen has all QOF requirements displayed for clinicians. Figure 4.6 exemplifies a kind of prompt 'Has QOF Alerts', as the mouse hovers over the purple appointment slot. The manager can open the patients' record and put in the drop-box which QOF indicator needs prioritising.

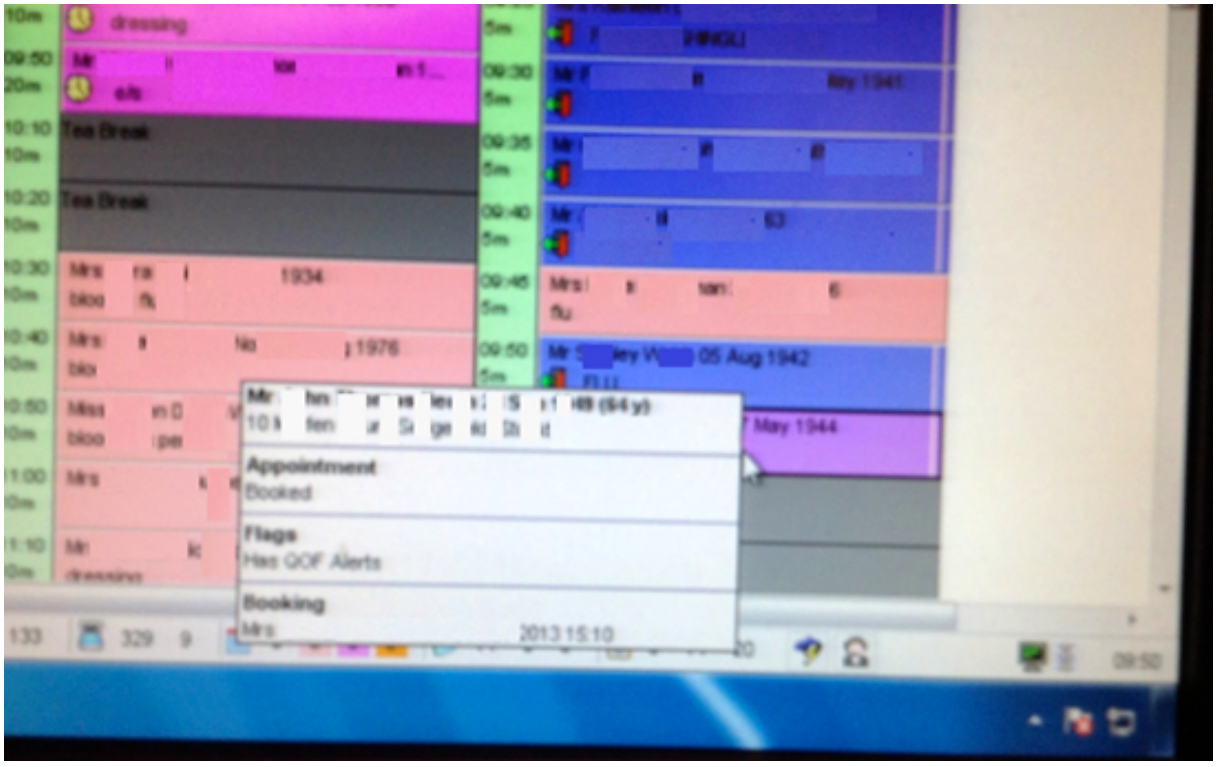


Figure 4.6. Prompt (Flags) indicating that the patient 'Has QOF Alerts'.

The above alert pops-up as soon as a clinician's mouse hovers over the patients' slot to call them in. If the manager adds a specific QOF target to the above drop-box, the staff will know that the manager is following and monitoring them. They cannot be 100% sure that managerial team will really be looking or tracing back their activities, because the health staff

cannot see if that is the case, or understand the real need for that activity as it becomes routinised. Hence, the IT system allows partners, the managerial team, and each member of staff to survey who is doing or not doing their 'QOF bit', even surveying themselves. As Foucault (1977, p. 207) highlights:

> There is no risk, therefore, that the increase of power created by the panoptic machine may degenerate into tyranny; the disciplinary mechanism will be democratically controlled, since it will be constantly accessible 'to the great tribunal committee of the world'.

In other words, professional autonomy is being even more reduced through this Panopticon 'democratic' regime, where anyone of the practice staff can check who is doing or not doing their 'QOF bit':

> *'…You know…by the computer system and things like that…I know that I'm better on System One than half of…the partners…and I know that I do a lot of QOF…and so…sometimes you feel a bit demoralised by it'.* [GP 8]

In this regard, I asked a GP if the QOF alerts put by the managerial team in the patients' slot influenced him/her in doing the 'QOF stuff':

> *'Yeah, yes…sometimes it does…because sometimes it depends in which surgery you are at…on the appointment booking they'll see what bits of QOF still need to be done…and if they do that, then I'm more likely to do it, because, I guess, you are thinking: "Somebody knows what needs* [to be] *done here and if I don't do it, then they'll know it that I've not done it".* [GP9]

The above GPs are speaking about a hierarchy, which is characteristic of a disciplinary method and its imbalanced power relation. However, what surprised me was the natural acceptance of this surveillance mechanism, through QOF prompts being put on patients' appointment slots to just 'remind' the staff about the parts of QOF that need to be done, as mentioned by a member of the QOF team:

> *'What we call a "Big Brother approach", after the George Orwell book…we use that term a lot…Big Brother, and…it means someone overlooking you, which was…hmm…hmm…it was…George Orwell who described a sort of police state…where everything you did was monitored…and therefore…and…it was called "1984", but that whole…police state was called Big Brother…so, we use the term all the time…hmm…and…no,* [on the contrary] *it*

works well because…it's people being prompted in what to do, because they weren't always look in their computer…to find out…so, it works well...and…we have to keep on reminding people that this is how we get paid…you know…if…would you go to work and not get paid?' [GP5]

As a precious economic resource, QOF points need to be constantly monitored to secure or maximise practice incomes. In this regard, staff compliance to QOF duties is a key managerial strategy. For instance, in practice 'B', I was observing the administrative staff doing an audit, counting how much each of health professional had acted upon specific QOF alerts during the preceding weeks, as requested by the managerial team. Thus, from time to time, doctors' and nurses' performance is checked, especially if they are lagging behind, which tend to be the case. This monitoring process is very efficient in spotting those who are not acting on the prompts, as highlighted in a QOF meeting [M1]:

MF1: *But, you know, it's clear that they are not using the template because all of the questions are there for them to put in…*

GP5: *Yeah, I think we need to really hit the ground and when it's the first time…*

MF1: *We need to 'name and shame' them and…I'll pick out the people that are just not doing it properly…*

GP5: *Well, it worries me that people put the O2 sats* [saturation] *in and they don't check the* [QOF] *timeline…hmm…I've been telling people to check the* [QOF] *timeline for well over a year and I don't know why they don't…*

This concern about being 'named and shamed' by colleagues reflects the 'stick' part of QOF incentive scheme. The QOF scheme is not just about rewarding. The flip side of this surveillance and disciplinary technology entails punishment. This technology further restricts health staff autonomy, since they know the managerial team is observing them, or because they might lose a considerable part of their income.

It seems that QOF has increased an internal control over health staff activities. However, during the QOF 10-year period since its introduction, QOF has become normalised and not explicitly imposed by the managerial team over them, since it is 'voluntary' to the practices to adhere to QOF. The above phrase 'it kind of helps them out' highlights this acculturation development. Strathern (2000, p. 4) has described this internalisation process as

‘likely to be that of helping (monitoring) people help (monitor) themselves, including helping people get used to this new ‘‘culture’’’.

However, this continuous surveillance effort can be quite disappointing for the managerial staff, since clinicians usually ‘forget’ to act upon what has been highlighted by the QOF team. The following real-time demonstration of QOF monitoring process illustrates this context.

> *‘I added on: “BP, if possible, for QOF”. So, if I just view the record…going to “new journal”* [heading on the computer system], *and for whatever reason…she* [the nurse] *hasn’t managed to do that. So, that’s still…still red…which is a bit of a shame ((voice mood goes down, looking disappointed)). But I’m not in the consultation, so I’m not sure how the consultation…could have been a technical…hmm…dressing…*so, *what I’ve put here* [looking at another patient’s on the record while speaking to me]*…I said: “Check smoking status”. Again, that’s been missed…hmm…’* [MF2]

This member of managerial staff felt very frustrated because it seems quite easy to introduce these little prompts such as ‘please do a BP’ as the patient comes to the practice for something else.

> *‘Because I was thinking…while you’re doing the dressing you could be saying to the patient: “Do you smoke?”* [or] *“Can I just update your records?”…and we would have hit another QOF* [indicator]*’*. [MF2]

This frustration feeling builds up as the QOF team approaches the end of financial year and the pressure to hit the targets increases. Another way of monitoring QOF progression is through QOF team meetings. The complexity of QOF requirements and the monetary value attached to it entails that QOF team meets regularly, sometimes fortnightly or weekly, depending on the time of the year. Furthermore, QOF is brought in every other practice meetings in some way, shape or form to discuss a specific problem collectively or to raise practice team awareness about the QOF situation. In practice ‘A’ I was not allowed to attend the practice meetings at the beginning of the fieldwork and I only managed to get permission later on in March 2014.

However, I was fortunate enough to be in on one of its *Petit Comité* of a QOF meeting that happened in January 2014 in a GP’s consultation room. This allowed them to speak quite

freely about the QOF monetary context, some problematic targets and colleagues. The following dialogue gives a sense of the content of this meeting [M1]:

> ***MF1:*** *…but there must be an understanding thing* [problem] *because you jump on about the same things all the time and they clearly…there must be a missing element that they just not…they're just quickly doing it and not making sure that…*[QOF is being done]…
>
> ***GP5:*** *But I think some of it is their responsibility as they just don't see it as…so when an asthmatic comes in…they don't think is their job to make sure that the QOF is done…and that's a real problem, because, you know, they're working in a practice where the QOF is a quarter of our income…hmm…there's got to be an element of…you know: -"*[it] *doesn't matter much to me"…but I mean, it does…*
>
> ***MF1:*** *It does, it matters to everyone…*
>
> ***GP5:*** *You know, it's such a big part, so…hmm. So, I think with asthma we just have to accept …we just have to encourage them to…every asthmatic that comes in we make sure we're covered, but we're not going, we're not going…you know, if we get 15 out of 20* [QOF points] *then we've done OK…*
>
> ***MF1:*** *Fifteen?*
>
> ***GP5:*** *You know…or sixteen…*

The above dialogue portrays how frustrating it is for the managerial team to not have staff acting as they would want them to behave. It reflects how artificial, or counter-intuitive, this policy is.

I managed to attend a QOF meeting with nurses, as well as other practice meetings, described in Chapter Five. Since in practice 'A' the meeting space was used for both nurse training and practice meetings, some clues were left behind in this multipurpose space that gave me a good idea on how QOF was putting pressure on the professionals to reach the targets. This context was uttered by one of the managerial staff:

> *'He* [The QOF lead GP] *does presentations on a regular basis…usually around every three months, to kind of prompt people and say: "-Look…if we don't do this, this is the amount…we're going to lose. If we don't get people doing this, that's going to be the effect… and if you do this, this is all we need to do to do that"…because they might not just understand what is required'.* [MF1]

On the one hand, it is clear that QOF has induced a constant nudging method, or a 'stick exercise' to improve practices' QOF points achievement, by explicitly displaying the potential monetary losses if practice teams keep the same pace. On the other hand, this might affect health professionals' autonomy, as they have to prioritise things that practice need in order to get paid (Chapter Six, p. 165).

In QOF team meetings, members of staff survey each QOF indicator more systematically, trying to gauge where they should be at a particular month in the financial year. The non-achievement in certain QOF areas would prompt them to feed this information back into a practice meeting to raise awareness of and compliance with QOF targets. That was the case in practice 'B', where QOF team meetings were held once a month. I had the chance to take part in all of them during my fieldwork. The QOF meetings that I attended followed the order of the 'QOF indicator' summary spreadsheet from top to bottom. Figure 4.7 illustrates QOF indicator summary spreadsheet according to the projected 'end of year'. This organises the indicators and sub-indicators, patient count, missing patients, discriminated percentage by colour and points.

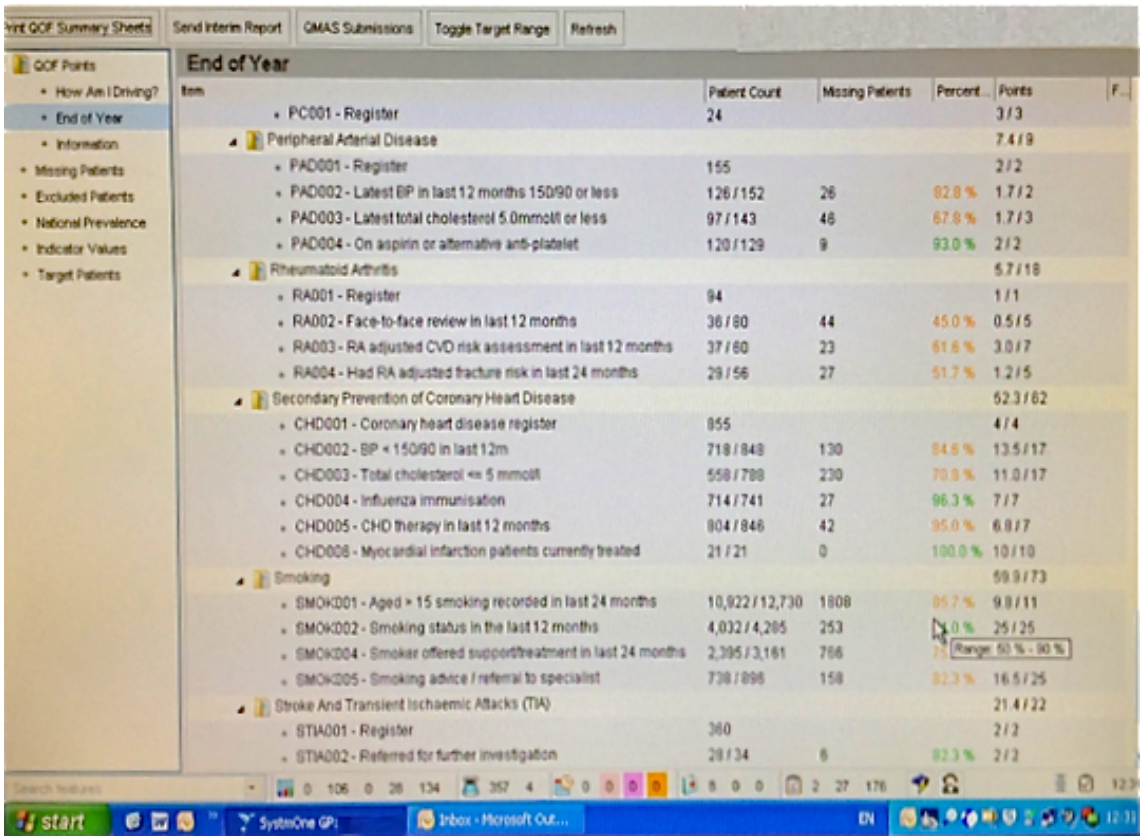


Figure 4.7. QOF indicators summary spreadsheet with its clinical indicator expanded to show the QOF sub-indicators and level of achievement (ratio), missing patients, percentage (by colour), and point ratio.

The following figure and dialogue show how this sequence is built in order to keep track of QOF indicators throughout the financial year. As the practice reaches the end of the year, the managerial team makes summaries (Figure 4.8) to help them concentrate on specific targets, as showed below [M2]:

Item	Outcome
1 Cytology	To Target
2 Contraception	To Target
3 Asthma	Reviews not to target we require 68 patients
4 AF	To Target
5 BP	To Target
6 COPD	Reviews not to target we still require 114 patients Spirom not to target we still require 37 patients **Action: to work out how many booked in and how many clinics needed.**
6. Cancer	To Target
7. CVD	Risk Assessment needs to be reviewed (Statins) we still require 3 patients **Action: Dr to look into**
8. CKD	CKD002 – Still require 30 patients CKD004 – Still require 26 patients
9. Dementia	DEM002 – Still require 24 patients **Action: to check all patients are booked in or have visits.**
10. Depression	DEP002 – Still require 10 patients **Action: Dr to look into**
11. Diabetes	DM002 – Still require 68 patients DM003 – Still require 98 patients DM004 – Still require 13 patients DM005 – Still require 103 patients DM006 – Still require 1 patient DM007 – Still require 16 patients DM008 – Still require 26 patients DM009 – Still require 38 patients DM011 – Still require 110 patients

Figure 4.8. Sample of the summary of QOF targets showing the numbers of patient needed for each sub-indicator and the assigned actions for lead professional (which have been deleted to preserve anonymity) followed by the words 'look into' or 'check'.

> ***MF6:*** *What I've done today, this morning, is going through <u>every single</u> target…two and a half hours…so, on here* [Figure 4.8] *it stands how many patients we need…<u>now</u>, to get the target…*

AHN: *OK, for each target…*

MF6: *Yeah…*

AHN: *So, cytology is OK…contraception is OK as well …*

MF6: *Asthmas we need 68 patients, we still have a few exceptions, but not 68…*

MF7: *Not 68, but we do have a lot…quite a few patients booked in…*

N4: *How many have we got booked in?*

MF6: *I don't know, really…*

MF7: *Unfortunately, it's quite a huge number...*

MF6 & N4*: Uff!! ((Releasing the air – exhaling)).*

The above meeting conversation coupled by a target list of missing patients at hand shows how practice QOF team prioritises the ones more likely to be achieved. These activities are then shared amongst the participants or lead QOF area staff. For instance, they might take a particular target to a nursing meeting to discuss a specific issue concerning a QOF target, such as in the case of erectile dysfunction in diabetic patients (see Chapter Seven, p. 186). The counting of patients that need to be chased and brought in for reviews or other QOF task is a constant process.

As Foucault points out, control and discipline became more important as Western civilisation moved from a sovereign to a state type of government where 'men and the things' in the territory became part of the political economy (Foucault, 1991a, p. 94). In *The History of Sexuality volume 1, 'Right of Death and Power over Life'*, Foucault (1978, p. 137) clearly explains this transformation:

> But this formidable power of death - and this is perhaps what accounts for part of its force and the cynicism with which it has so greatly expanded its limits - now presents itself as the counterpart of a power that exerts a positive influence on life, that endeavours to administer, optimise, and multiply it, *subjecting it to precise controls and comprehensive regulations* [emphasis added].

QOF thus represents the design and desire to manipulate, control, and regulate life itself. The QOF's disciplinary mechanisms are further explained as the next section addresses its practical space.

QOF's PRACTICAL SPACE

'Practical space' refers here to those activities that directly involve the patients, either by bringing patients to practice for reviews (in the case of receptionists) or by acting upon QOF requirements (e.g. during the clinical reviews or encounters). In the 'practical space' there are works that entail clinical expertise and there are other parts of QOF that can be achieved by either receptionists or administrative staff by means of templates. For instance, the receptionists can do part of 'QOF stuff' over the phone following simple electronic-template questionnaires to extract information about patients' smoking status or level of physical activity, as described in Chapter Seven (p. 182). The clinical aspect usually is shared amongst GPs, nurse practitioners, practice nurses and health care assistants. In general, nurses' clinical care is based on disease electronic templates, while GPs have a complementary role in filling out these electronic templates. The more complex or undifferentiated cases are usually left to GPs, and with regards to specific QOF parts, they cover more technically challenging areas (e.g. heart failure and depression) that require a different level of expertise.

Receptionists

The reception has a core function in general practice. Receptionists are the first point of contact for patients. It is mainly through them that patients access any of the available services. Additionally, members of staff use the receptionists to get in contact with patients, so they are the main point of connection in the communication process between patients and their health care providers. Apart from that, receptionists have an important role in issuing prescriptions for patients who are on repeat prescriptions for chronic conditions (Swinglehurst, Greenhalgh, Russell, & Myall, 2011a), and they also give patients laboratory tests results by phone if the information is available for them to do so. When a patient wants to see a GP, the receptionist tries to assess their need by doing a mini-triage (i.e. classifying patients' needs) and offering patients alternatives to GP consultations. For instance, patients might just need to renew a medication or they have a minor illness and a receptionist, in this case, might offer patients a nurse practitioner to deal with it, saving GPs' consultation time for more complex cases.

In regard to QOF, receptionists have the task of inviting and booking patients, according to a list of 'missing patients', for certain QOF indicators (Figure 4.9). These lists are produced by the managers or lead administrative staff involved in monitoring QOF and handed over to them. Therefore, when receptionists have 'free time' or gaps in their other

administrative activities, they can fill them with 'QOF stuff' such as phoning patients and inviting them in.

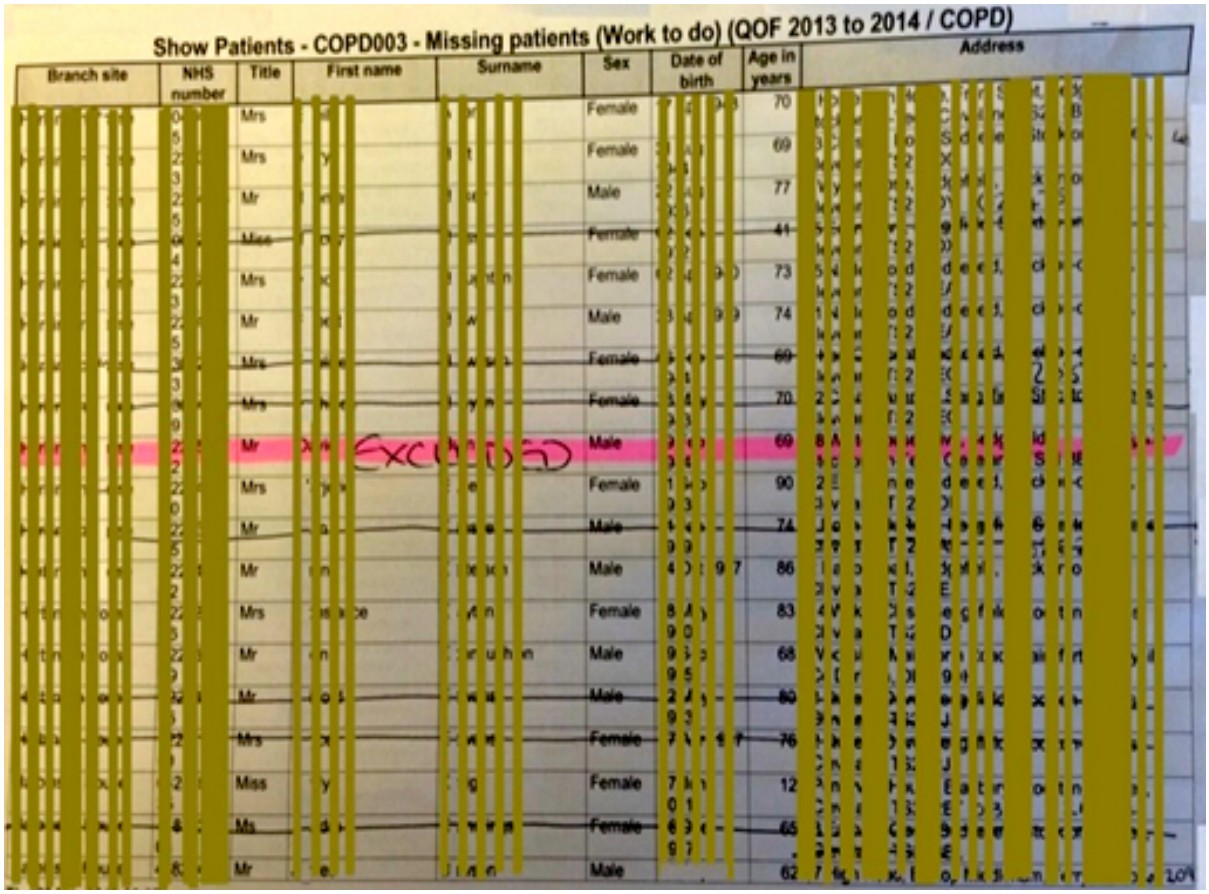


Figure 4.9. List of missing patients with COPD that needed review.

For example, with a list of patients in hand, receptionists will call the target patients and tell them that they are due for COPD review and will offer appointment slots that better suit patients' needs in order to improve compliance. This is a practical aspect of QOF receptionists' task: chasing patients as a managerial staff explained to me, in regard to the flu target:

> *'…Then the girls on reception will also…start targeting patients. So we found, over the past few years…a telephone call is better than sending a letter…so we don't actually send them a letter of invite…inviting them to come along. We…ring them when we know we have some appointments, then we can give them a range of appointments and they will…choose'.* [MF2]

The receptionists know quite well their patients' profile, since most of them have been working in the same function for years and accessing patients' records either for informing patients' laboratory results or by issuing repeat prescriptions. In practice 'A' most of staff

involved in the reception had been working there for more than five years, most have been living in the same community they cater for. Thus, they know the majority of patients and their potential for coming, as stated by a managerial staff:

> *'What we could try and do is on our daily basis the doctors…and…and nurses would do that through consultations, but we would…hmm…print off a list…send it to the sites…now, the girls* [receptionists] *in the sites and supervisors would know their patients, so…they would have a good idea of…who they think is going to come in, who would tend to come for these reviews and who wouldn't…and…we've got to try to concentrate on everybody, but primarily the ones that we can get into these appointments'.* [MF1]

Clearly, QOF has induced general practice to concentrate '*primarily*' on those patients that they *'can get into'* the appointment slots, as emphasised above. Thus, the QOF scheme has set up selective criteria shaped by the easy one to get in or those more financially rewarding for the practice, as further discussed in Chapter Five. Receptionists can prompt patients to check some particular single QOF target that is flagging up into patients' appointment screen, while they are waiting for the consultation:

> *'Even though…hmm…it may indicate here* [referring to patient's appointment slot] *that they have those QOF alerts, that comes up of the appointment stage as well. So, the girls* [receptionists] *on the phones downstairs could say…if they had the opportunity: - "While you're here go and get your blood pressure done before you go in and see the doctor"'.* [MF1]

Receptionists are involved in some QOF work, particularly when it reaches towards the end of financial year (i.e. from December onwards until 31st March) and the pressure for hitting the targets increases. The indicators they target usually revolve around preventive measures or things in the public health domain. While observing the receptionist team working in one of the practices, they were assigned a QOF-task, which meant calling patients and asking about their physical activity and smoking status as further discussed in Chapter Seven. This was seen as a strategy worth doing since QOF does not specify which health staff should be prompting patients about their smoking behaviour. According to one manager:

> *'Certainly, towards the end of the QOF year…last year the receptionist staff had a big push on…hmm…asking patients as they came to the desk to book in* [about] *their smoking status'.* [MF2]

Clinicians

This refers to frontline health staff such as GPs, nurse practitioners, practice nurses and health care assistants. The main focus was to see their attitudes as well to understand their ideas and concerns about QOF. Clinicians are organised in a gradient of levels according to the uncertainty and/or complexity associated with patients' conditions. General practitioners tend to deal more with complex cases while nurse practitioners work in the grey or transitional areas, on a mix of undifferentiated cases (e.g. minor ailments) and well defined activities organised through protocols and templates. Finally, practice nurses' main activities are running a clinic guided by protocols, such as in diabetes, COPD, and asthma. Health care assistants tend to do part of the overall clinic framework such as measuring blood pressure (BP), taking bloods, doing the spirometry assessment, administrating preventive screening questionnaires, and advice (e.g. smoking cessation and physical activity level).

This organisation reflects the amount of time available for consultations. Paradoxically, despite GPs seeing more complex and undifferentiated cases, their consultation time is framed in 10-minute slots. Nurse practitioners usually have 15-minute slots whereas practice nurses' consultations range, in general, from 20 to 30 minutes in order to cover all tick box requirements for a disease-oriented template. Thus, the more definite is 'the case' the more time and things to cover, while the more undifferentiated it is the less time is made available for patients. This shows that the value is placed on measurable things, rather than on more subjective aspects of care, i.e. the adoption of a scientific bureaucratic model of health practice, as discussed in Chapter Two (Harrison, 2002). Similar to the managerial space, the practice space has also been influenced by QOF's IT system, as follows.

IT system: channelling 'contradictory voices'

Today's model of consultation is no longer a clinician-patient relationship, but rather a 'clinician-computer software-patient' relationship due to the intense use of electronic patient records (EPR). As Swinglehurst, Roberts, and Greenhalgh (2011b, pp. 11-12) point out, the use of EPRs have a 'pervasive material authority and contributes voices in its text, which may remain silent but which are consequential to the interaction, both within and beyond the ''here and now'''. Computers are not just passive elements in the consultation, an empty space to be filled in: they demand actions. From tools, computers have become a third part in

the consultation, not just something that distracts clinicians' attention, but agents themselves, that actively inform and request things to be done or offer alternatives in terms of coding or diagnoses.

> '[QOF] *interferes with the natural flow of the consultation, because what it does...it's, I mean, it's the problem with computers taking away from a natural, you know, interaction between you and another person…you spend 3/4 of your time looking at your computer screen and not actually engaging with your patient at all, because you have at the back of your mind, you know, ((pretending a voice speaking into his mind)) "-This is how we're getting paid…I'm going to tick these boxes, I'll ask the questions, or…'* [GP4]

This 'little voice' is in fact materialised by computers' software, which constantly tell practitioners their needs that have to be fulfilled. Thus, GPs' consultations have become a complex space of distinct 'voices' with GPs having the role of deciding ("distributing"), 'whose voice will be preferentially heard' (Swinglehurst, Roberts, Li, Weber, & Singy, 2014, p. 9). The above GP's remark, *'this is how we're getting paid'*, reinforces how the QOF scheme, via its EPR, is discriminating against different types of information predicated on its value and potential for 'manipulation, measurement and external scrutiny (in the case of QOF the 'value' has direct financial consequences)' (Swinglehurst, 2014, p. 25). Hence, information that is measurable is more valued than other more subjective aspects of care.

The requirements embedded in the QOF scheme begin even before the patients get into the consulting room, since while hovering over the mouse to click on a patient's appointment slot, computer pop-ups are requesting some QOF targets that should be done or prioritised. This prompting system is, directly or indirectly, constantly reminding health staff about QOF requirements, present through several icons or symbols in every space of the computer's screen. Figure 4.10 (left hand side) shows a pop-up requesting the need for registering blood pressure and urine sample for albumin. On the right hand upper corner there is a 'QOF' highlighted in yellow and an iconic 'eye'. The latter is a link or shortcut to eye checks (retinal) review, though metaphorically it reminds one of what is concurrently is, a surveillance system.

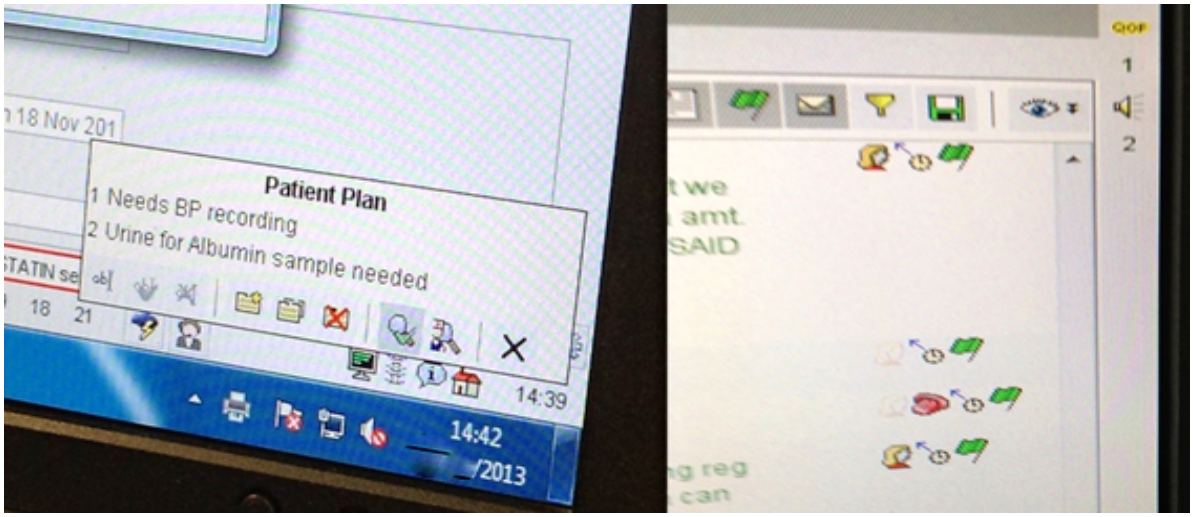


Figure 4.10. Prompt/reminder on the left-hand side of what is needed and QOF icon in yellow on the right-hand top corner (and an iconic 'eye') of the computer screen.

When opening the front-page of patient's record, computers are actively telling professional health staff what needs to be done for that particular patient in terms of QOF requirements. Figure 4.11 shows a patient's front-page record with all QOF indicators in red, meaning that they need to be acted upon. Clinicians have to select or tailor which one to deal with during the patient's 10-minute consultation.

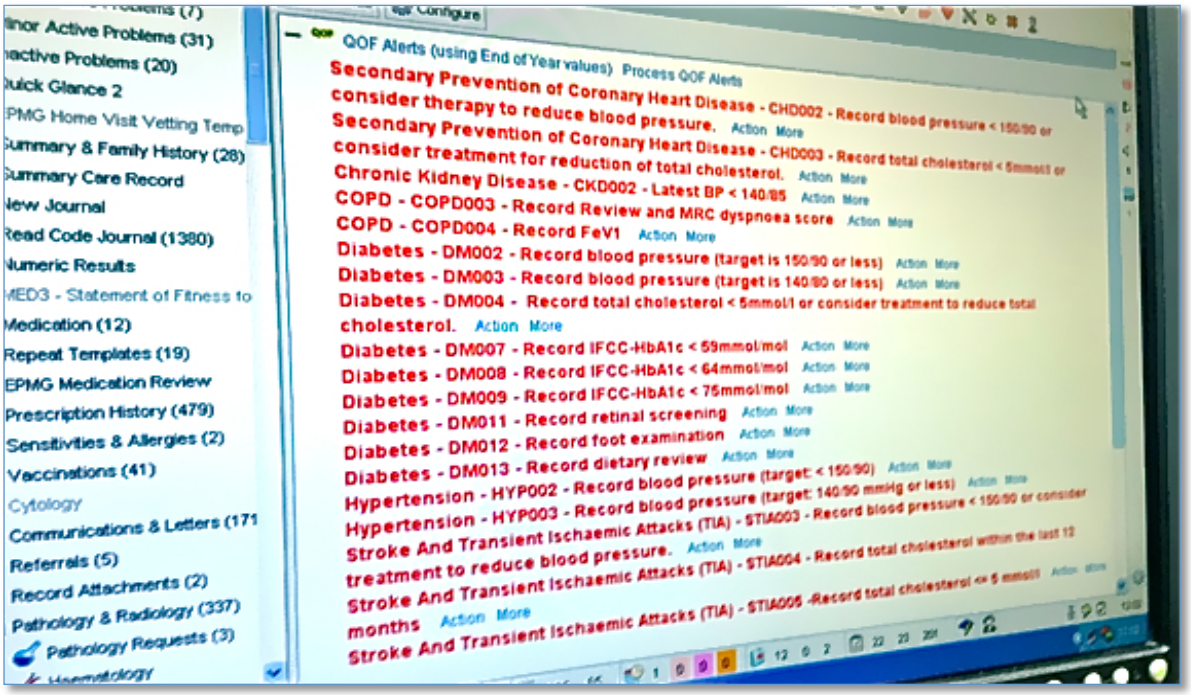


Figure 4.11. Patient's front-page record with several clinical indicators needing to be acted upon, such as cardiovascular preventive actions, COPD, diabetes, hypertension, smoking cessation, stroke, etc.

The ‘dialogue’ between clinicians and computer is very dynamic and they need to pay attention to what the computer is telling them. For instance, when GPs type what patients are explaining to them during the consultations, codes are automatically offered and those codes that have QOF value are highlighted in yellow (Figure 4.12). The same situation occurs when GPs type either the physical examination main findings or the potential diagnosis into the patient’s record slots for registering the consultation. The clinicians can choose to write in free text or to pick the Read code standard text that allows for audit and QOF information extraction (Chapter Seven, p. 194). The first step in the data production line is to ‘extract’ and generate the information from the patients as they are the prime source of ‘raw material’ or the ‘standing-reserve’ in Heidegger’s words (Chapter Two p. 6; Chapter Five, p. 124). Therefore, a robust IT system is set to alert health staff in each clinical encounter about the ‘bit’ of information needed.

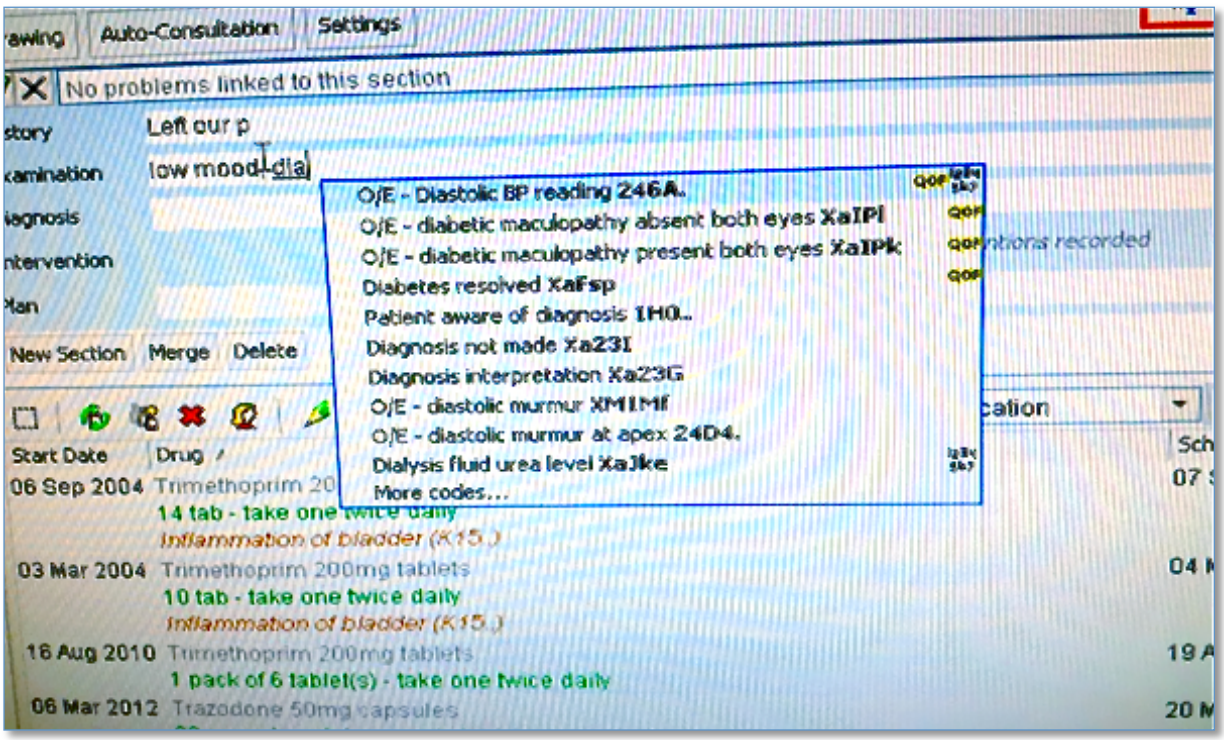


Figure 4.12. Read code simultaneous presentation as a GP is typing into patients’ record slot. The three letter ‘dia’ immediately brings potential codified QOF Read codes starting with ‘dia’ such as diastolic blood pressure (BP), diabetic maculopathy, etc, highlighting ‘QOF’ in yellow.

In this regard, consultation has become a tripartite endeavour where a management framework is constantly infiltrating the consultation, prompting clinicians to do things in order to get the QOF points (Heath, 2007). In this managerial codifying process built-in

EPRs, "patients' stories morph into bytes of data; the particular becomes generalised; the complex is made discrete, simple and manageable and uncertainty becomes categorised and contained' (Swinglehurst, Greenhalgh, & Roberts, 2012, p. 12). Thus, with this track-typing coding system, narrative-based medicine is being challenged. Additionally, by focusing on 'getting the QOF points', clinicians might be compromising the patient's agenda or the 'principle of patient-centred medicine'. Certainly, the practice team can opt not to enable the active-typing codification function, but this would put at risk some QOF points as clinicians might forget which code to choose.

This IT system saves doctors' time by automatically linking their actions, as in the case of simple straightforward requirements such as adding aspirin to a patient with coronary heart disease, a process whereby the computer will do the link and not consume much time during the consultation. Administrative members of staff can run an audit targeting specific codes in order to verify any miscoding, fixing the problems, and saving doctors' time. Problems arise when a template is required to be filled by other health professional staff. In the case of GPs, they usually do part of it, or do it opportunistically, if time allows them to do so:

> *'Hmm…I think it's taken a few years for us to get our heads around…hmm… the bureaucracy of it…and we're now trying to assimilate it into what many people think is the essential part of practice, which is the doctor patient-relationship…and that's something we've been studying and, of course, it's how we try and fit it in…without altering our relationship with our patients…we do that through it…opportunistically, as we've said, we just slip something in here and slip another question in there…I…if you can do that…hmm…cleverly…then I think patients…I suppose are not* [in] *disadvantage.'* [GP6]

The above utterance reflects the constant effort to adapt what was potentially a more 'free style' of consultation into QOF requirements. In regard to QOF templates, in most cases GPs have a complementary role, unless when it is their duty to diagnose a condition, which QOF has structured to do it in a particular fashion. The typical example is the depression indicators, which require a biopsychosocial assessment (BPA) to be registered at the same time as the diagnosis (coding). This will be discussed in Chapter Eight.

Adding QOF on top of a 10-minute GP consultation

In the UK general practice, the 10-minute consultation has become the standard timeframe for a patient to see a doctor. The Royal College of General Practitioners states that GPs

should have a holistic approach to their patients, but despite the ageing population and the increase in case complexity (Mangin, 2007) GPs' consultation style is framed as 'one complaint per patient per encounter'. This is stated in one of the practice's policy leaflets as follows (Figure 4.13):

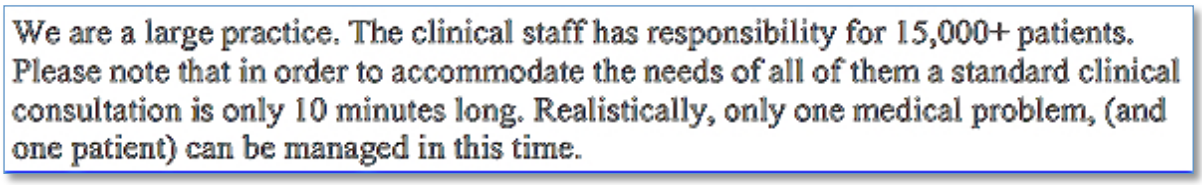

We are a large practice. The clinical staff has responsibility for 15,000+ patients. Please note that in order to accommodate the needs of all of them a standard clinical consultation is only 10 minutes long. Realistically, only one medical problem, (and one patient) can be managed in this time.

Figure 4.13. The general practitioners 10-minute consultation standard: one complaint per patient per encounter. Source: practice leaflet.

In this approach to patients, it is difficult to see any sign of holism. It seems more to reduce patients to their component parts (or complaints) rather than an approach to the whole person. Moreover, from a strictly clinical point of view if '83% of all correct diagnoses can be made by taking of a complete medical history from the patient' (Napier et al., 2014, p. 1612), this implies that more time in taking a clinical history would result in better clinical outcomes and potentially reduce unnecessary laboratory tests. However, this timed consultation typology and context, in apparent support of what is experienced as clinically more effective in UK general practice, has been put under stress with the introduction of QOF.

During one of the consultations that I shadowed, after the patient left the GP's consulting room, the doctor turned to me and explained: -*'In Britain GPs have 10-minute consultation and patients usually bring more than one complaint. It seems that patients do not know how time is precious for us'*. I then replied saying: - *'In the GP training programme the GPs trainees are taught the 10-minute consultation model for the Clinical Skill Assessment (CSA)'*. The answer to my remark was that: - *'In the CSA it's always one problem and in reality things are more complex with patients having more than one problem, and on top of that we have the QOF work to do. It's quite demanding'*.

As expressed by the above GP, to this complex scenario of multi-morbidity ageing population is added QOF's disease oriented requirements. All these have to be done in the same amount of time, which was traditionally reserved for a single complaint. The extract below illustrates this context:

> *'...To look at chronic diseases and make sure we're managing it, but the…the targets* [have] *become too strict, so, then…now…becoming an end in themselves. So, I'll quite often have a*

consultation where I'll have a patient who has eight QOF alerts, and they may come for a completely unrelated problem and quite rightly in my 10 minutes I want to focus on what they've come in with, but all the time I'm very aware that I got to ask them...you know... are they still not smoking? They weren't smoking last year, but, still not smoking this year?...hmm...I…It just feels as if it's conveying quite different things into the consultation'. [GP2]

This GP statement highlights QOF intrusiveness mediated through patients' electronic records. Another opportunity to do QOF work is when patients are invited to their annual medication review. In this case, in theory, the patient would not come with any other demands and GPs, or even nurse practitioners, could do the part of QOF that is missing.

'...If we had 10 minutes just to purely do…the QOF, then fine…in practice that doesn't happen…occasionally patients come for…like a…medication review, which is a good opportunity to do that, but if they come with other problems, as you have seen today…there was a lady that came with four problems…trying to do that in 10 minutes…and deal with QOF on top of it…it's unrealistic…and the worry is…that you miss things…you don't concentrate on one problem for long enough…hmm…you don't deal with the problem…correctly…you skim it…you deal with it superficially…and…you may miss something…' [GP14]

The above GP concern is that they eventually end up 'missing important things' during the consultations. This reflects that QOF's selective character may have a detrimental effect on non-incentivised and measurable aspects of patients' care.

While in most cases GPs do try to do QOF opportunistically, a turning point occurs when QOF starts to influence their consultation style more: the approaching end of the financial year. One GP explained this phenomenon to me while I was in the reception: -'*You came in a good time (i.e. November), because we are not in a more difficult moment of the year'*, inferring that I still could see some consultations 'with a bit of QOF' in it and if GPs missed the QOF they would not be so worried about it, because they still would have some time left. The scenario changes after December, he said, as they usually become 'very QOF oriented'. The GP did a nice metaphor relating QOF seasonality with the school year: - '*In summer we have a great relief'*. Meaning that they have finished the last financial year (31st March) and the consultation becomes more '*driven by doctor's style'* again. Then, he explained that in the *'autumn term'* they try to get things done, but if they cannot make it for

whatever reason, they still would have another chance in '*winter term'*, but after that, '*QOF drives our activities'*. This seasonality matches the QOF increase in score pattern described in Chapter Five, which tends to 'peak up' from December onwards, as stated by a member of managerial staff:

> *'…There's a lot…a lot of work in the beginning as well as in the end…you get to May and things start to settle down and we run pretty smoothly…hmm…and it runs like that for about six months and that starts to, like we say, to peak up around about December, January for the end of QOF'.* [MF5]

As remarked above, from December onwards GPs' consultations tend to be more influenced by QOF activities, helping the practice to hit the targets. However, during the year most QOF chores are left to the nurses' team to be performed through specific clinics such as diabetes, COPD/asthma, and anticoagulation control. This job division was clearly mentioned by some GPs:

> *'If I hit the QOF points then I hit the QOF points, but we have...we've organised the system in our practice where we've got chronic disease recalls and monitoring, which is done by the practice nurses'.* [GP3]
>
> [or]
>
> *'I'm…I'm perfectly happy getting paid to tick a box…but I'm not happy about having to do all this clinical work for dubious reasons like hitting a target… that's dangerous!* [To] *tick boxes you get a manager…a nurse…somebody else to do it! And then* [it] *is cost-benefit, you know… if I employ a nurse who I make more money employing the nurse doing all that, I don't do it myself!'* [GP1]

The above GPs' quotations represent a trend to use 'the least qualified (and least costly) team member' in chronic disease management, reinforcing its data management approach rather than patient-centred type care (Swinglehurst et al., 2012, p. 8). This work division has been seen with 'criticism from within the nursing profession' because the increased extra-work that QOF brought to general practice was not reflected by an increase in nurses' earnings (Peckham, 2007, p. 43).

Nurse team activities and clinic reviews

The Figure 4.14 describes the main division in nurse activities in general practice extracted from a GP surgery website, corresponding to the standard information of their work description.

Practice Nurse Appointments

The Practice Nurses are all experienced Senior Nurses whose training allows them to offer confidential discussions and advise about all aspects of health. They provide monitoring and management for people with diabetes, asthma, heart problems, epilepsy, chest problems and mental health problems. The Treatment Room Nurse performs smear tests, childhood immunisations and gives health advice and immunisations to those travelling abroad.

Appointments can be made via the Receptionist.

Nurse Practitioner

The Nurse Practitioner is available to see patients with problems concerning the following:

- Coughs, Colds, Ears, Throat, Sinuses, Chest Infections, Rashes, Musculoskeletal (e.g. Back Pain), Abdominal Pain, Vomiting, UTI, Headache, Allergies, Wound Infections and Bites.
- Anxiety, Depression, Skin Problems, Hay Fever, Contraceptive Pill, Abnormal Bleeding, Lumps (anything that may need an urgent 2 week referral).
- Heartburn, Indigestion, Period Problems, Breast Problems, Constipation, Diarrhoea.
- All childhood illnesses.

Health Care Assistants

The Health Care Assistants support the work of the Practice Nurse by doing blood tests, performing other tests e.g. spirometry and monitoring blood pressure. They provide comprehensive smoking cessation services and can monitor weight loss.

Figure 4.14. Nurse staff work description and stratification in general practice. Source: general practice website.

During my fieldwork, I had the opportunity to be in the nurses' consulting room and to interview them, exploring the time gaps when available during their clinical sessions. The nurse practitioners are a quasi-GP with their role situating between practice nurses and GPs. As described in Figure 4.14, nurse practitioners see undifferentiated cases as well as chronic diseases with the support of electronic-templates.

Practice nurses' work is based on protocols and templates. These are 'standardised data entry tools' 'to assure that data collection is uniform and accurate' (Checkland,

McDonald, & Harrison, 2007, p. 699). However, this tends to frame both the style and time of consultation, provoking ambivalent feelings since it includes other things apart from that particular condition such as screening for depression, alcohol consumption or simply measuring blood pressure for all invited patients, regardless of their condition, as in the conversation below:

> ***N3:*** *I think what the templates are doing is… they're trying to catch other QOF marks as well, not necessarily for…that condition…like the blood pressure check, you know, if you have…some of the asthma patients that you're bringing in…*
>
> ***AHN:*** *…are hypertensive…or no…most are not…*
>
> ***N3:*** *most of them…the younger ones are mostly <u>not</u>…so, do we really need to be doing their blood pressure every time they come in? Or are we just trying to hit the target for a blood pressure target…because they are not…hypertensive patients? So…I suppose they've designed the templates so that they fit…"<u>one</u>…thing fits everybody"…(.hh)…regardless of their age…'* [N3]

As the conversation above shows, templates are designed to optimise QOF achievement points rather than necessarily patients' needs as '*one thing fits everybody'*. As Arthur Frank (2002, p. 45) remarks, 'placing people in categories, the fewer the better, is efficient [value for money]; each category indicates a common treatment: one size fits all. But again, treatment is not care.' Thus, this template-driven style of consultation gives prominence to the disease component via 'biomedical data' collection, to the detriment of 'more personal' information, i.e. patients' illness dimension (Swinglehurst et al., 2011b, p. 12). In this regard, QOF requirements necessarily result in templates needing to be comprehensive enough to extract as much information as possible when a patient comes to see a nurse. Despite templates being centrally produced, they can be tailored according to the practice needs, as depicted through this conversation in a QOF meeting [M4]:

> ***MF8:*** *…and I think what* [Mrs. Nurse] *was saying is that…we've got different templates and lot of things repeated, so…*[it] *will save time by…mere…changing the templates…*
>
> ***GP11:*** *Because our templates…we've always been adding and adding…and adding…*
>
> ***MF8:*** *I know…she said…if you just repeat this…*

N3: *Yeah, like what she said to me…she said some of the stuff that you've gone* [through] *is just stupid…*

MF5: *What we'll do…we'll have a working meeting, where we'll review…clinics, clinic times, what they are doing in them and…hmm…all the templates.*

I had the opportunity to attend two practice nurse clinics: one for diabetic patients and the other for COPD patients. The approach in both was quite the same. It resembles a factory line production divided into steps, with different experts checking over patients' bodies. I had the chance to follow a patient across the four steps of the diabetes clinic: first with the nurse, second with the podiatrist, third with the dietician, and finally, with the GP. All of them were following their bit of QOF diabetes requirements through templates.

The COPD clinic is divided in two steps (spirometry with health care assistant followed by a check with a practice nurse) and, sometimes, three - if the patient needs a prescription or his/her health condition warrants a further consultation - with a GP. These two experiences exemplify how the biomedical model – which tends to reduce patients to its component parts, being very mechanistic – has been foisted on general practice with QOF requirements (Checkland et al., 2008). Hence, it seems that in the UK general practice is heading towards a Fordist industrial plant production line by fragmenting the healthcare process across different body experts, coupled by a consultation style based on a centrally driven template for data collection.

According to Gramsci (1999, p. 561), the achievement of the Fordist 'planned economy' requires a new 'type of man', a move from 'craft' work mode of production (individualistic) to an industrialist one, which 'is still at the stage of psycho-physical adaptation to the new industrial structure, aimed for through high wages' (Gramsci 1999, p. 572). Therefore, from 2004 'high wage' contract strategy policy-makers have promoted a standardised-mechanistic type of care rather than a personalised crafted one. Indeed, it has been acknowledged that the NHS clinical governance framework 'looks very much like a Fordist labour process, featuring increasing degrees of specification, standardisation and centralisation of control' (Harrison, 2002, p. 475).

As a biomedical technology, the QOF scheme electronically integrates two poles embedded in Foucault's biopower concept: the anatomopolitics of the human body and the biopolitics of the population. These two poles are realised by two interconnected spaces: the practical and the managerial space. The former concerns with the 'body as a machine' that

needs to be disciplined and optimised; the latter deals with the 'body as species' aiming to impact on its mortality, the level of health, life expectancy and longevity (Foucault, 1978, p. 139).

Additionally, being a surveillance system QOF has been improved by software programming either through prompts, reminders or pop-ups (Peckham, 2007). These reminder systems have two functions. The first warns health staff about patients' bodily biomarkers (i.e. levels of blood pressure, cholesterol, haemoglobin A1c) and 'health' check requirements from reception to consultation room (the anatomopolitics/individual component). The second function monitors the biopolitic/population component via the 'QOF indicators' summary spreadsheet, helping managers and administrative staff in chasing patients and reducing the number of 'DNA patients' - those who usually Did Not Attend - according to Checkland, 2008. This context reinforces how human lives have become an important locus of power for government interventions. For this reason, QOF belongs to a rationality that harbours:

> The disciplines of the body and the regulations of the population…this great bipolar technology-anatomic and biological, individualising and specifying, directed toward the performances of the body, with attention to the processes of life characterised a power whose highest function was perhaps no longer to kill, but to invest life through and through. (Foucault, 1978, p. 139)

CONCLUSION

In this chapter, we have seen how Foucault's concept of governmentality is still relevant to the contemporary society. The QOF scheme, therefore, can be understood as a 'system of permanent registration', not to protect us from a 'plague' (Foucault, 1977, p. 196), but for enhancing population health profile by disciplining individuals to conform to centrally-driven health policies. Biopolitics is at the heart of QOF managerialism that 'endeavours to administer, optimise, and multiply [life], subjecting it to precise controls and comprehensive regulations' (Foucault, 1978, p. 137). In the management of a population, chasing individual patients to come to the GP surgery to be reviewed, measured, and checked against pre-established clinical standards has become a paramount tactic. As Foucault (1991a, p. 95) has put it, the art of government power is exercised through tactics: *'to arrange things in such a way that, through a certain number of means, such and such ends may be achieved'*. This

chapter highlights that in the QOF era general practice's working process presupposes a Panopticon regime:

> In this central tower [managerial space], the director may spy on all the employees that he has under his orders: nurses, doctors, foremen, teachers, warders; he will be able to judge them continuously, alter their behaviour, impose upon them the methods he thinks best; and it will even be possible to observe the director himself. (Foucault, 1977, p. 204)

The microphysics of power relation becomes very apparent as QOF reaches the end of the financial year. In this context, GP practices are pressurised to hit the targets, altering the consultation style. The QOF scheme, then, permeates the daily activities of health staff through quantifiable templates (yes/no guidelines), which tend to reduce health professionals' autonomy. This is particularly true for nursing staff in their clinics, with GPs having a complementary role, helping filling the template's gaps. Thus, by analysing general practice's managerial and practical spaces, QOF can be seen as a contemporaneous form of governmentality in Foucault's terms.

Chapter Five

QOF INDUCED COMMODIFICATION: ANIMATING THE NHS BIOECONOMY

This chapter sheds light on the commodification process with the introduction of the QOF in UK primary health care services and its importance to the NHS internal bioeconomy. Firstly, it addresses the theme of commodification as a phenomenon in general practice. As patients in the UK do not need to pay for medical services at point of delivery, the theme of commodification sounds at first counter-intuitive. However, this ethnographic study will show that the NHS internal market has expanded into the interface between health professionals and patients, commodifying their relationships. Secondly, it justifies, strengthens, and updates Foucault's governmentality concept by situating general practice within the NHS's bioeconomic internal market. In this context, biopower has become biocapital leading professional staff to chase patients' bio-values in order to extract their bodily token-information to be traded within the UK bioeconomy. Finally, I shall suggest this commodification process is seeding a commercial model of care in UK general practice. In this regard, QOF harbours a high-risk strategy, which is both individualising and totalising, in order to economically capitalise prevention. This pre-emptive strategy is breeding a speculative model of medical practice, the major function of which is to animate the internal bioeconomy of today's NHS.

COMMODIFICATION

The analytical approach to the theme of commodification follows in the footsteps of other medical anthropologists such as Nancy Scheper-Hughes, Margaret Lock, and Lawrence Cohen. They have used a broad definition of commodification as it applies in medical anthropology contexts. For them, commodification encompasses 'all capitalised economic relations between humans in which human bodies are the token of an economic exchange that are often masked as something else – love, altruism, pleasure, kindness' (Scheper-Hughes, 2001, p. 1). This definition comprises two important stances: first, the notion of the body as a 'token for exchange'; second, the rhetoric of benevolence, which in the case of QOF comprises discourses of quality of care, health improvements and disease prevention (Heath, 2010). As Scheper-Hughes (2001, p. 1) writes, 'in the global economy "the body" is

generally viewed and treated as an object, albeit a highly fetishized one, and as a commodity that can be bartered, sold or stolen in divisible and alienable parts'. It is this objectification, fragmentation, and standardisation of the human body for quality care management that has fostered a commodification process within the internal-market of the UK National Health Service. The commodification of health care provision in a free-market society such as the United States is more obvious and has been heavily criticised. As Barbara Rylko-Bauer and Paul Farmer (2002, p. 477) contend:

> Corporatization and commodification of medicine are continuing to shape the financing and delivery of health care in the United States. The orientation increasingly is one of selling "product" rather than providing care, to "consumers" and "clients" rather than to patients, with a reliance on competition to control costs and encourage "efficiencies."

In the US health care system medical provision is usually treated as 'service commodities' to be sold as '"packaged" for the care of body parts and conditions (as breast, stroke, obesity, aneurysm centres)…transforming health care services into medical commodities for a public eager to buy' (Stoeckle, 2000, p. 141). In this market-driven health provision model, the assumption is that health care is equivalent to any other goods to be purchased. As Pellegrino (1999, p. 244) states '"consumers" and "purchasers" will be free to choose among providers selecting the best "buy" suited to their individual needs'. Thus, the US healthcare system is of course very different from the UK.

In Britain, people do not have to pay 'out-of-pocket' for medical services at the point of delivery. The NHS represents a tax-based 'third party payment system [which] attempts to socialise the financial risks of ill-health by a pooling of risk and of financial provision' (Harrison, 1998, p. 16). This creates a situation that prevents the commodification of health care provision as a 'product' to be consumed according to patients' purchasing power. The questions that come to the fore are: (1) How is it possible that commodification has taken place within the NHS? (2) What are some of the consequences for general practice and for the NHS alike?

Chapter Two highlighted the introduction of an internal market within the NHS by Margaret Thatcher's conservative government. This initiative divided a previously monolithic structure into a purchase-provider framework, the providers being 'self-governing hospital trusts' and purchasers the former 'health care authorities' and 'GP fundholders'

(Laing et al., 1998, p. 22), currently represented by the clinical commissioning group (CCG). Thus, rather than having an external relation with patients as consumers of health care services, the NHS has a built-in market relation amongst its own competing members. GPs are an important element in this process, representing a 'big market' target since they provide the daily care for the UK population. Hence, it is from inside the NHS, hidden from the gaze of 'laypeople' that this commodification process is occurring.

Since the commodification is internally oriented, the way to document and analyse this phenomenon is to research UK general practice as a case study. Ethnography permits a backstage approach, changing the perspective from an outsider to an insider point of view. This chapter provides both the empirical materials - collected through interaction with people immersed in the substantive commodified context - and inputs from the literature that discusses the commodification process. It is constructed in a chronological fashion following the progression through fieldwork, based around important events such as focus groups, managerial spaces, nurses' meetings, and QOF recoding sessions.

Managerial space: 'patients as walking bags of money'

The theme of commodification in general practice became apparent to me as an empirical fact in the beginning of my fieldwork at site 'A'. I was still thinking about the focus group, carried out a week before at the GPTP, and the transcription process. The focus group guided me to think that QOF seemed to be driving GPs to an extreme, due to changes introduced in the 2013/14 GMS contract, when QOF target thresholds were raised (Doran, Kontopantelis, Reeves, Sutton, & Ryan, 2014). As the process of transcribing the focus group was still very alive in my mind, a collision of information occurred: one from 'the ground' and the other from the transcript content. For instance, a GP expressed this concern, as follows:

> *'…now patients are walking bags of money that you have to get money off them…by doing certain tasks…instead of a patient that you should be just saying: "- We've got* [a] *problem and we need to…"…and that's a danger, you know'.* [GP1]

This idea of patients being '*walking bags of money'* and the conflict that it has brought into the doctor-patient relationship in terms of patients' versus doctors' agendas stuck in my mind and stayed there in a kind of standby state. It seemed ethically questionable that doctors'

attitudes should be influenced by money rather than by patients' best interest (Pellegrino, 1999).

In the initial phase of learning how QOF was organised in general practice, I had the opportunity to have two separated meetings with managerial staff. These took the form of private mini-classes in their own offices, which lasted roughly 45 minutes each. The content covered the use of the IT system to monitor both staff members' QOF activities and QOF's indicators progression during the financial year (Chapter Four, p. 75).

In these private mini-classes, the MF went into detailed explanations about 'System One's' main operational characteristics with regard to QOF and the utility of the IT system in helping MFs to keep track of QOF indicators. Thus, side-by-side we (managerial staff, the 'computer/software' and I) started a candid interaction and discussion in order to improve my understanding about the QOF's managerial space. To clarify some points the managerial staff even selected some patients' electronic records to demonstrate the way they worked. The conversation was so natural and open that one of them did a 'print-screen' of the main computer pages, sending it to me via email, as I was introduced to some key aspects of the IT system. This improved my comprehension and the accuracy of the data collected. What follows describes the atmosphere of our interaction and the idiosyncratic nature of QOF's commodification process.

> *I'm sort of focusing on the flu. So, in diabetes we are at…68%...hmm…so if we did nothing more, that's how we would be finishing the year. So…in CHD* [coronary heart disease] *we are at the 74.7* [%]*, now the government initial target was to get 75%...hmm, so I've been in the phone with Mrs. 'Administrative' - who's the supervisor at* [the other branch] - *this morning, because I've noticed there were some appointments…free on the* [health] *care assistant this afternoon, I said: - "Look Mrs.* [supervisor], *to get 75% we just need one more CHD patient, can you try to find me one?" So she's…got on the case and she's now booked some Flu appointments for this afternoon. So, to get to that, to the 75%, but as you can see to get the full points…the range is 56% to 96%...(.hh)…so we need to keep…chugging away at them…and for the strokes and TIAs* [Transient Ischemic Attack]*…hmm…we are at 69.7% and 114* [patients] *to go. So, I use these reports quite a lot…hmm…it's also good for 'target patients', see…you can either sort it by who is the most profitable to us…and we could chase that patients...hmm…or who has the most* [QOF] *alerts…* [MF2]

In the above extract, patients are reduced to conditions to be chased: *'We need one more CHD patient, can you try to find me one?'* This tends to depersonalise care, objectifying the way patients are treated, based on population surveillance mechanisms (Checkland et al., 2007). Additionally, the IT system permits managerial team to classify patients *'by who is the most profitable' to them, so that they 'could chase that patients'*. Figure 5.1 demonstrates that a monetary value is individually attached to each patient. This utterance coupled by the screen-capture figure are powerful discoveries and loops back into what the GP in the focus group was saying about patients becoming 'walking bags of money'. The QOF scheme has priced patients and now they have monetary value, which varies according to how many disease conditions are attached to them. Therefore, this leads into a constant theme of 'chasing patients', one of the consequences of the commodification process discussed in Chapter Six.

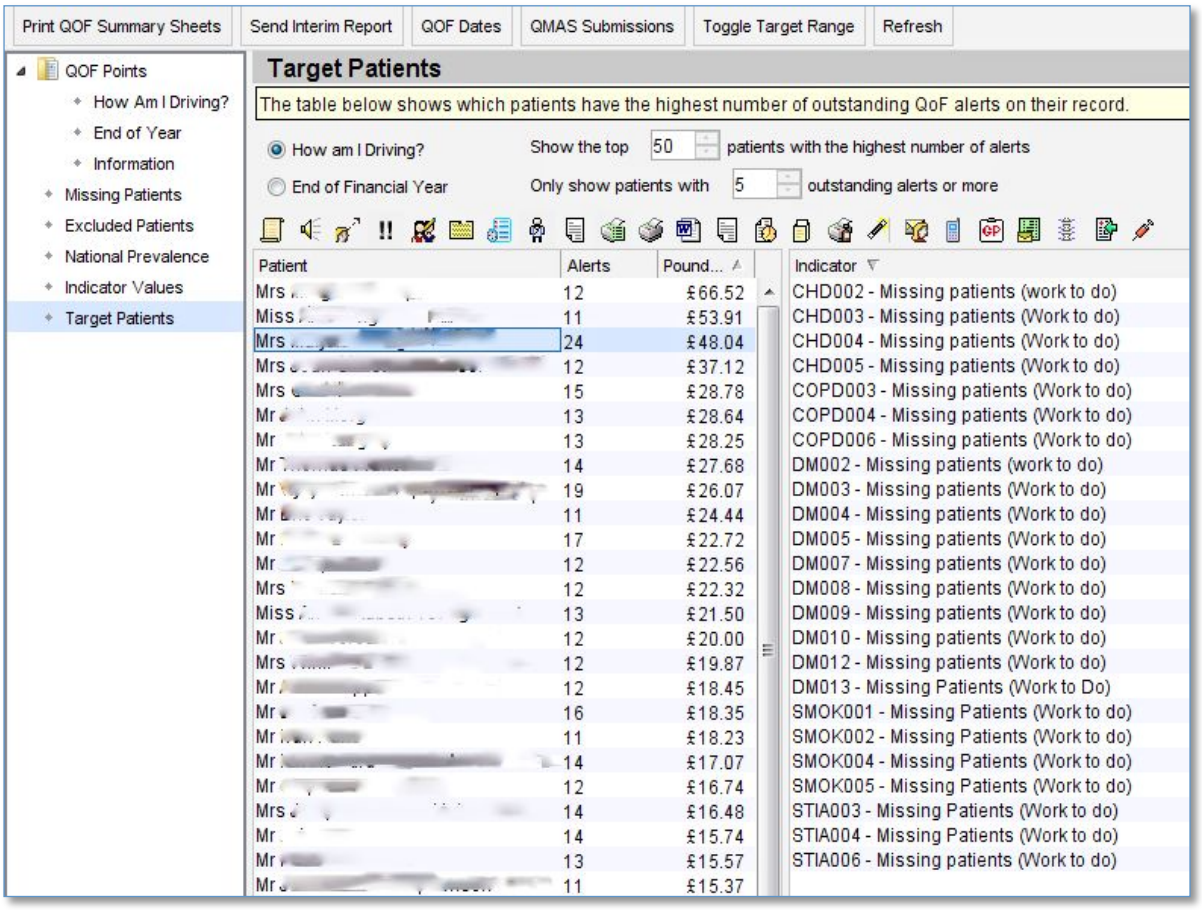


Figure 5.1. List of target patients collated by patients' monetary value.

The screen-capture Figure 5.1 was generated through the 'target patients' computer heading in the 'QOF indicators' summary spreadsheet (Chapter Four). It shows a list of patients with corresponding number of QOF alerts and patients' value, collated by how much a patient was worth to the practice. Furthermore, it emphasises a patient with the highest number of QOF alerts (24), totalling £48.04. When this patient was selected, the software automatically displayed in a drop-box on the right-hand side of the screen the QOF-tasks that needed to be performed according to the number of diseases attached to him/her. These were (in this case) coronary heart disease (CHD), chronic obstructive pulmonary disease (COPD), diabetes (DM), smoking (SMOK), and stroke and transient ischemic attack (STIA). The highlighted patient in red illustrates the '"package" for the care of body parts and conditions', which QOF has priced (Stoeckle, 2000, p. 141).

The issue of QOF's monetary characteristic and the commodification process became clearer after my first surgery meeting at site 'A'. It was a nurse-training meeting. As mentioned in Chapter Three (p. 53), health staff turnover has been a reality in both practices and, consequently, updates on QOF rules and training were necessary. Additionally, QOF's rules change every year, leading practices to address the nurse teams about grey areas and where to put their effort, in order to improve practices' QOF profile.

Practice nurse-training meeting

The nurse-training meeting started with a quick discussion of two clinical cases as an example of staff shortcomings in carrying out their activities and simultaneously embedding the 'QOF bits' in their consultation. Then, it moved on by presenting QOF key concepts, basically how it worked. In sequence, came an explanation of the practice's current 'points situation' and the importance of doing it, since the whole practice depends on QOF income resources to run according to its budgetary targets.

In this regard, one concern was that the practice QOF trajectory was in a descending curve: two years ago they were down by just one QOF point, the previous year they were down by 14 QOF points, and the prospect for the 2013/14 financial year was to have a 217 QOF points reduction. This would inevitably lead to a significant financial loss, affecting the maintenance of the current practice infrastructure. Additionally, the theme of quality was brought in by the same GP saying that 'rightly or wrongly, the QOF is also regarded as a quality standard'. As the GP continued to explain, QOF is not just 'about the money', to

some extent it is the 'representation of how we're doing' in general practice'. In other words, the government and the clinical commissioning group (CCG) will evaluate the GP practices based on their QOF achievement levels. Figure 5.2, a PowerPoint slide used during the meeting, summarises this initial conversation. It highlights the main purpose of the nurse-training meeting, to ascertain *'how can we make improvements* [in QOF points] *without being too intrusive/demanding?'*

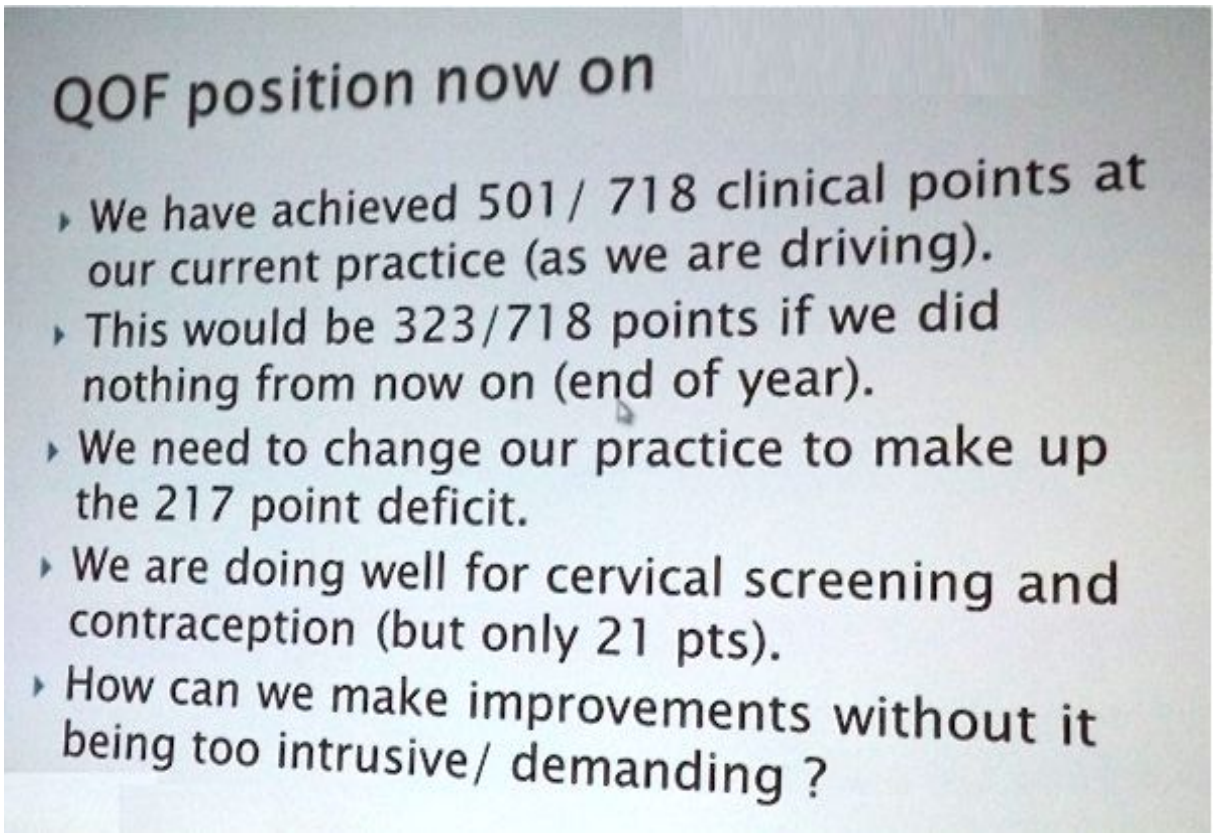
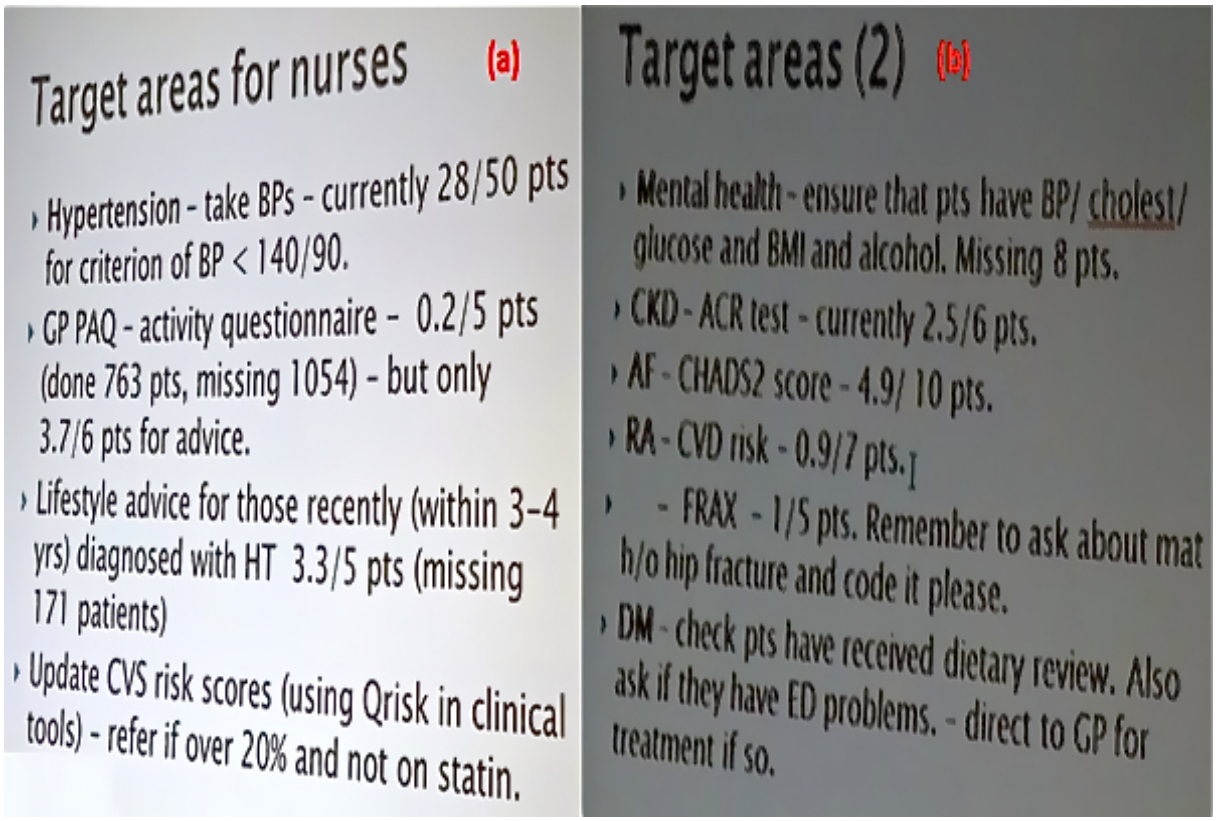


Figure 5.2. PowerPoint slide summarising the practice QOF situation in mid-November. The slide shows the current situation of 501/718 (as we are driving) and the 'real' and worse projected scenario 323/718 QOF points (end of financial year) 2013/14. If the practice team keeps the same pace the estimated deficit is 217 QOF points.

After the initial contextualisation, it was made clear to the nursing team that QOF was part of the nurses' responsibility and not a 'plus'. In other words, no additional financial reward is given to nurses for doing 'QOF stuff', since it has become an integral part of their activities. Then, the QOF team lead went through the main target areas that required the nurses' attention and input. The following slides summarise the main points discussed with the nurse team focused on the following QOF targets: hypertension, GPPAQ (GP Physical Activity Questionnaire), lifestyle advice, and cardiovascular risk, and their respective QOF points' situation (Figure 5.3a). Other QOF domains requiring nurses' attention in order to improve

the practice's overall QOF achievement included: CKD (Chronic Kidney Disease); AF (Atrial Fibrillation); RA (Rheumatoid Arthritis and Fracture Risk Assessment Tool - FRAX); DM (Diabetes Mellitus); and ED (Erectile Dysfunction) (Figure 5.3b).



Figures 5.3a and 5.3b. PowerPoint slides with the nurses' QOF target areas, showing that nurses have a big role in QOF.

The above picture shows how target-driven general practice care has become. The meeting was basically a checklist of things for nurses to concentrate on 'pushing them away from a focus upon vulnerable individuals [i.e. a patient-centred approach] towards a population-based definition of their work' (Checkland et al., 2007, p. 696).

I was not expecting to see the computerised summary spreadsheet of patients' monetary value, again, at least not see it being openly discussed without any embarrassment (Figure 5.4). But, reflecting back, why it would cause embarrassment, when it was part and parcel of the whole 'quality' framework? The question is: Do the patients know about this? I do not think so, at least not at this detailed level. Thus, during this 10-year period of QOF, the scheme has naturalised the commodification process whereby patients, money, and points are easily interchangeable 'things'.

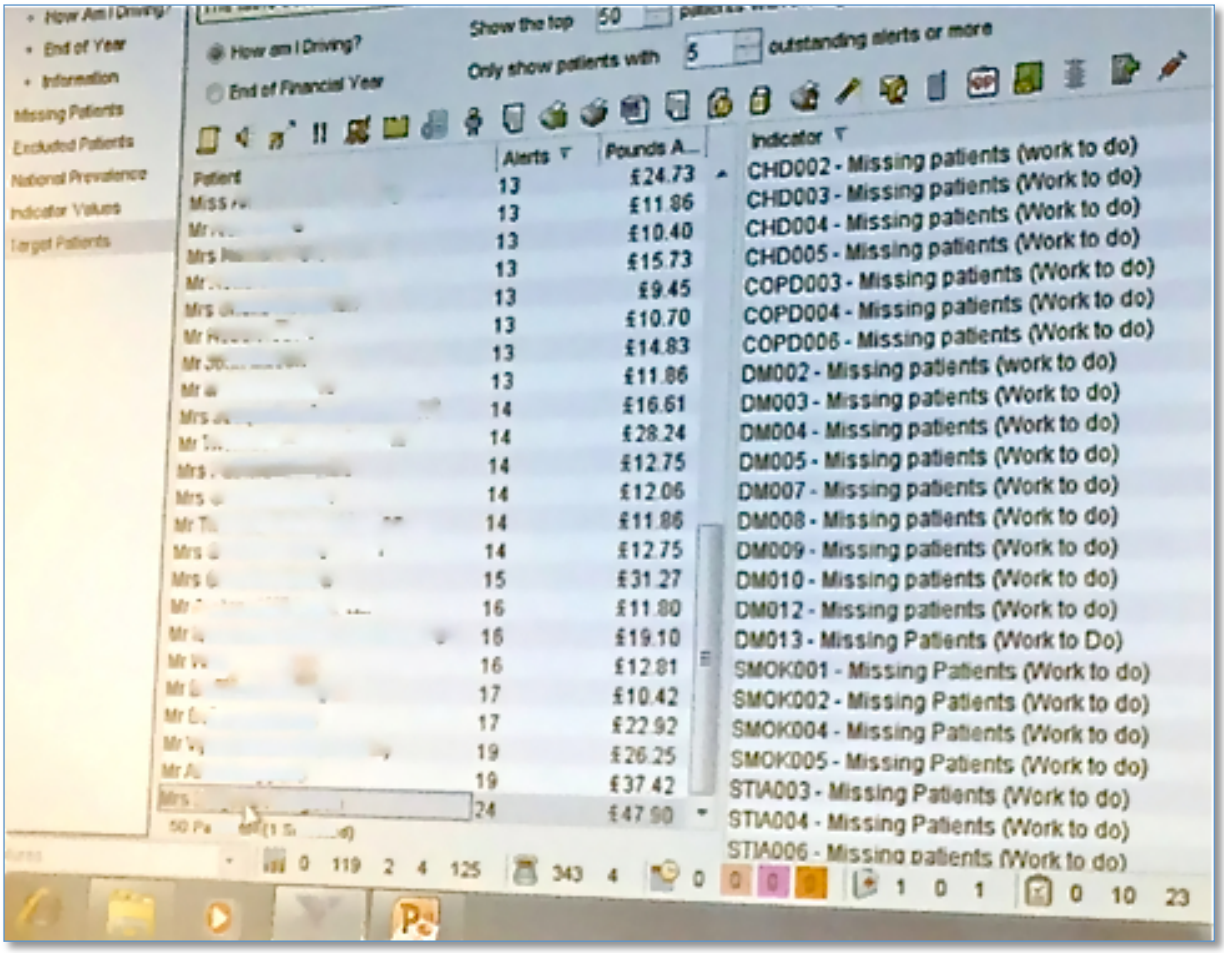


Figure 5.4. QOF patients' monetary value projected during nurse training meeting.

With regard to commodification, patients instead of being units of care have been fragmented by QOF's disease oriented model. This process of commodification attributes value to each component part of a disease management framework. The 'target patients' demonstrate that patients now vary in their intrinsic or added value, where before the QOF era this was not the case. The capitation formula for general practice is based on the population profile and not on individual cases (Simon, 2008b). Hence QOF, structured by 'disease management protocols (to improve outcomes, reduce costs, and standardise care), is, in effect, providing programmed service commodities', embedded in diabetes clinics, COPD/asthma clinics, and so on (Stoeckle, 2000, p. 141).

In the NHS, these packages of activities - organised within each compartmentalised 'disease box' - are negotiated internally by the Department of Health and the British Medical Association (Doran et al., 2014). At this level of negotiation, patients have no participation in what they might regard as good health service provision. In the US health system, health as a commodity needs a 'minimum of governmental regulation' leaving quality to free-market law

(Pellegrino, 1999, p. 244). This is not the case in the UK where health as a commodity was introduced into general practice through an Act of Parliament.

In this institutionalised context, the nurse meeting discussion was basically about how to improve the figures, not necessarily patients' care. The message was clear: how to get these patients in for a review, fill the templates correctly, act on the QOF alerts in order to build up QOF points, and improve the overall QOF profile grid. Furthermore, how the nurses did it was not an issue, as long as they ticked the boxes. For instance, as they were explaining about dietary advice for diabetic patients' review, a GP partner said: '-Do not worry too much about the quality of the advice', as long as 'somebody talks to you about food, that counts'. In other words, tick the box in order to document it, regardless of the quality of the interaction.

In order to understand what is going on, a good approach would be to step back from the individual cases and see what QOF has done in terms of fragmentation of patients, their complaints and healthcare activities. The QOF scheme communicates about a conception of the body itself, which is an intrinsically mechanistic one. As Sharp (2000) points out, it is how the body is conceptualised that has the potential for de-humanising and decomposing the body. It is by having an understanding of how the body has been conceptualised that 'one [might] explore how (literally and symbolically) fragmentation and commodification occur' (Sharp, 2000, p. 288).

The QOF's mechanistic approach to the body (Checkland et al., 2008) is intrinsically fragmentary since it links GPs' income to selected portions of general practice activities, divided into small countable and auditable units. Then, a monetary value has been attached to each unit, creating a spectrum of possible financial gains. These units are then assembled into several disease management templates, producing a series of small boxes to be ticked or filled up with short pieces of information that allow for easy extraction and/or for an audit to be performed (Checkland et al., 2007). This process of fragmentation was nicely depicted by a GP:

> *'The problem with this whole area is…it's the classic cliché that we use: 'salami slicing work'…twtch, twtch, twtch, twtch, twtch ((making gesture with his hand like chopping with a cutting knife))…lots of little bits (.hh) and we end up with the huge sausage of (bratwurst*?)...[GP4 agreeing: -*Yeahh* ((laughing))]*...that's exactly what it is!'* [GP1]

Although symbolic, the idea of 'chopping' or 'slicing' the health care activities to produce commodified resources needs to be addressed 'as both objects and as semi-magical and symbolic representations' (Scheper-Hughes, 2001. p. 2).

Recoding Clinical session

The whole process of commodification returned even more clearly later on during my fieldwork, this time at practice 'B'. In March 2014 I arrived at the GP surgery at 08:30 in the morning for a whole session (time duration 4:41:15) with a GP to do a QOF code amendment activity. This is a new role brought by QOF, where general practitioners or qualified nurses are responsible for looking at certain targets and checking for coding issues. Thus, QOF has produced a new form of health staff role: the re-codifier, as inferred by a managerial staff:

> *'In a large place like this, it's industrial, I mean, you're talking* [about] *hundreds of people on a list…and somebody has to go through the list, and assess them and check what needs to be done and call them in, right. Now…you probably wouldn't want to do that, but if you <u>have</u> to, you <u>have to do it</u>. So we have to take you* [a doctor] *out of the surgery and say: -"Sit there, go through that list of 400 people, please, look at it and tell us what needs to happen!" and you think: -"Hu! ((Exhaling the air)) 450 or so, I <u>don't want</u> to do that!" So, what you then see is: -"Well, could we get somebody else to do that?" So, what you've seen with QOF is…you've seen, you know…different arrangements where…some practices have said: - "Well, we brought a doctor in specifically to do that" or "- We've got a good medical secretary, who can certainly do a lot of it" or "- We've got one of the nurses who can do all of it", and so on and so forth…and so, you look at different ways of systemising that particular realm. But in a practice of this size it's phenomenally#...you know, it's a significant amount of work…'* [MF4]

This is a new role that a GP, a qualified nurse or 'somebody else' would take on doing QOF amendments, usually once a month. The necessity for someone to do this task could increase or decrease depending on the need for checking QOF code quality and how well the practices were doing in relation to the end of the financial year. This new task was being performed in both sites.

I had the opportunity to see indicator amendments being made for diabetes, heart failure, and depression, as described in Chapters Seven (p. 203) and Eight (p. 229). Some aspects of coding were handed out to other staff, but some required professional expertise.

The GPs thus play a big part in this process, as well as those nurses with special training in clinical areas such as diabetes, COPD/Asthma and so on.

> ***AHN:*** *Would it be…would it be just you doing this or someone* [else] *will help you…within this task of looking into the files and* [recode things]…
>
> ***GP11:*** *Hmm…I'll get somebody else to do them…I'll get…the nurses to look at some of them...hmm…OK…hmm… like the…diabetes, I can put the diabetes nurse to look at it and see if we can exempt them…if they are in hospital review or if…they are on insulin…and all sorts of things that we can't control for that…so we can exempt them…and…if they are on maximum tolerated treatment for the…anti-hypertension…then we can exempt them, but, that is a big thing to look at…the…the hypertension is…(.hh)…how many do you look at? You know…how…how do we do that?*

This activity was seen sometimes as a 'waste of time', but equally as a 'money-making' opportunity, as a GP was explaining to the managerial colleagues in a QOF meeting [M1].

> ***MF1:*** *Yes, well, what I've thought we could do these ones over the phone* [referring to the contraception targets]…
>
> ***GP5:*** *We can…we can…*
>
> ***MF1:*** *We could do these telephones for…*
>
> ***GP5:*** *It's only…eight missing patients but it worth three points…so, it's quite a lot of points for a very, very, limited number of…there's not many things in QOF where your limited number of patients buys you so many points…and I've managed to pick up lot of ones like…hmm…cardiovascular, there're 8.5 out of 10* [points now] and [it] *was actually zero, but we were only dealing with 17 patients. So, I managed to get…this is…you know, whom I said, you know, whom I said sometimes…I'm bragging, I've said: "- I can make you four thousand* [pounds] *in one session" ((gently laughing))…hmm…you can, if you go from nil to ten and that's so…hmm…my time so far it's been really good value* [for money] *but unfortunately it gets less and less…hmm…but I've picked up the learning disability…hmm…the Down Syndrome…we've got one patient and he's worth one point…*[in fact] *three points.* [GP5]

The above conversation is illustrative of how QOF has in part skewed doctors' and nurses' original role of caring for patients to assure their practices' income. Thus, the concept of attaching money – '*We've got one patient and he's worth three points'* - has proven to be a potent driver in reshaping GPs' and nurses' roles in general practice, but more importantly, it

has changed the nature of care by 'commodifying' patients themselves or their biological extracted by-products. The QOF commodification mechanism attaches points to patients' bodily biomarkers (i.e. level of cholesterol, blood pressure, and haemoglobin A1c), which results in token-information to be exchanged for pounds. This process started to become clear as I moved into the practical space. The recoding session in March was quite productive, because I could explore more in depth the monetary aspects of QOF.

At some moment in the QOF recoding session, we were talking about the QOF points' framework and how it was translated into monetary units and the effort involved in trying to hit the targets by going backwards and recoding things. The following passages further illustrate the commodification process:

> ***GP11:*** *…the thing is…if you do that, there's only…what?...1.7 points in it…*
>
> ***AHN:*** *Is it worth doing it? That's a question…*
>
> ***GP11:*** *Is it worth?…whereas <u>that</u> one…it's 20 points in it…*
>
> ***AHN:*** *Yeah…that's a lot…yeah…20 points…I don't know how much it is in terms of money?*
>
> ***GP11:*** *OK…hmmmm…indicator's value…right…OK…here we are* [looking at the computer screen]...
>
> ***AHN:*** *Just a second…*[My mobile rings and I have to answer it]…

The above initial conversation illustrates again the trade-off mechanism built within QOF. In other words, is it worth doing it? This led us to explore the QOF point values as the GP carried on explaining:

> ***GP11:*** *OK…*[reading the computer screen headings]…*'points achieved'…'pounds achieved'…'points per patient'…'pounds per patient'…'pounds per point'…that's 'pounds per patient', how about pounds per points?…four pounds per patient…so, if you get…100-point patients, you get 400 pounds…so if you get…say…600 patients…what 200 patients, you get 800 pounds…so…to get maximum target…we are…*[lower voice while making calculations]*…1700 pounds off…No! More than that!…yeah…'missing patients'…*
>
> ***AHN:*** *The total is…is this?* [£] *4700 and you're currently three thousand…*
>
> ***GP11:*** *Pounds achieved at the moment* [1700] *and pound achievable is three thousand…so, we're three thousand off…so we could get three thousand pounds…*

AHN: *OK…so, a lot of money…*

This ongoing dialogue refers to the amount of money involved in each of QOF clinical domain areas, the package of commodified services that has been commissioned by the government for GPs to deliver as a quality standard. This can be characterised as 'government induced demand' for health services within the NHS's artificial internal market. This is, in principle, different from patient-induced demand, typical of a free-market. In the continuation of the dialogue, the GP scans through several QOF clinical areas, not necessarily identifying which was which:

GP11**:** [the GP carried on showing on the computer screen the money available for practice according to some targets]*…You can get a [£] 1700 by doing the review…you can get [£] 1900 by doing the review…OK…that's easily achievable…comprehensive care plan* [for mental health]*…look at it [£] 460…I'm spending some time doing that…hmm…depression doesn't come up because…it was a new indicator* [the BPA]*…so, we couldn't correlate with the previous one, so it's really difficult to say how much we can get…so, you know, so 12 pounds? I wouldn't worry about that; 37 pounds…hmm??? ((In doubt))…you know…it's in their hundreds that we'll be looking at…OK, GPPAQ* [GP Physical Activity Questionnaire] *[£] 3000…this…[£] 1009…[£] 770…*[for] *risk assessment…and I need to look at… and that's only three patients…*

AHN: *So, three patients are worth more than…*

GP11: *259 pounds per patient, if I can get those three…*

AHN: *Wow! It's quite an imbalance!*

GP11: *Hmm, yeah, so…you know, there are some we get a lot more and some we don't get much at all…OK…hmmm…*

AHN: *How do they decide how… this condition's worth more than the others?*

GP11: *I have no idea…I've got no idea…I've got no idea…OK, so that 1300 pounds to review… OK…so… it is achievable…this one we're very annoyed about it: how do we <u>not</u> get the cholesterol under five…for secondary prevention for heart disease?!... <u>We have</u> to get that…so people are not acting…on the blood results.*

The imbalance in the allocation of value, as well as who decides upon the target relevance for general practice is completely alien to ordinary health staff. The QOF scheme constitutes a vertical imposing framework due to the amount of money involved in its 'quality framework', despite its 'voluntary nature'.

The QOF value allocation imbalance illustrates the detachment from what is called 'socially necessary labour-time' in commodity production, from the Marxist point of view. In this regard, the 'use value' of a commodity is 'related to other commodities by the amount of labour-time necessary for the production of each' (Timmermans & Almeling, 2009, p. 23). As documented in the above dialogue, health staff members are alienated in this process, which to some extent reflects that the points' allocation to each 'package service' does not necessarily represent the health staff workload output. Thus, QOF points' allocation fluctuates according to what policy-makers want the practice team to concentrate on, as depicted in the case of depression indicators described in Chapter Eight. What is important in the QOF commodification process is its 'exchange value', which is politically established, as stated by Arjun Appadurai (1986, p. 3):

> The gist of this perspective can be put in the following way. Economic exchange creates value. Value is embodied in commodities that are exchanged. Focusing on the things that are exchanged, rather than simply on the forms or functions of exchange, makes it possible to argue that what creates the link between exchange and value is politics, construed broadly.

In the above dialogue, one can see, read and sense the monetary currency exchange of QOF: '*Four pounds per patient, so if you get 100 point patients, you get 400 pounds so if you get say 600 patients…what 200 patients 800 pounds…'* It is almost a sort of 'QOF money' (£-QOF) that is in circulation now in the UK general practice. This £-QOF is then linked to body biomarkers and health conditions. Then, the decision to do or not do a health activity might change from the patients' real needs into a business logic based on increasing profits or minimising losses.

The £-QOF, conditioned by things that practices must do in order to generate their revenue, distorts the relationship with patients. Therefore, the objectives of a healthcare service get skewed and targets become a fetish that practices need to get. The following dialogue with a nurse strengthens the compulsory nature of QOF:

AHN: *But the problem with QOF is that…apart from bringing to our consciousness the care that we should be looking at the patients, they've* [also] *attached money to it…*

N4: *Exactly…*

AHN: *What…what do you think about this…this "dangling a carrot"?*

N4: *I think it's wrong! I think it's wrong to dangle…the carrot, the money…hmm…and…they set the targets unrealistic…hmm…and it's becoming like…an industry…in an industry where I worked…prior to this, they set targets because that was the way they earn their money. Now, this is what? The government don't…they're…setting targets for us…to get our money…to look after the patients! You know…and the patients should be entitled to the care…and not just because…they are dangling this carrot in front of us to give us the money…to care for the patients when we should be able to care for the patients anyway…without them dangling this carrot to say to us: (.hh)…"-You're going to get this if you do this"…(.hh)…hmm…*

This restrictive deal embedded in QOF "You're going to get this if you do this" distorts the nature of professional practice, which usually would give time for both health staff and patients to accommodate their needs. Therefore, QOF has transformed 'EBM' guidelines into a sequence of protocols based on a series of steps - the 'if then' logic - by means of attaching monetary incentives. Additionally, the fact that some indicators are worth more than others or require 'too much effort for too little gain' (Alderson et al., 2014, p. 6), and even that some individual patients can bring more money than others, has produced disequilibrium prompting GPs to select the 'big carrots'. As stated below, in this trade-off monetary environment, general practitioners might act very pragmatically, weighting their activities in terms of potential economic gain or losses:

'You know, I go around and there is a huge difference between training practice GPs and non-training practice GPs...hmm...well, that's my experience! And...hmm, it's more black or white, so, they will say: - "Is it cost-effective to me getting this target or not?" So, they won't look [at] *it necessarily as driving training or systems, they will look it at as a business proposition. So, is it worth recording smoking history? Or, let's have a look as how much per… you know...and say: "I'm making a loss, then I'll stop doing that...hmm… they will go for the low level large carrots…the small, little, (linny-twinny?) carrots at the top of the tree they won't bother…and if there's a stick they will retire early…basically, the thing, that's right...that's what they do.'* [GP1]

The business model and the trade-offs are possible because of QOF's abstract nature, which allows for the depersonalisation of care. It seems very clear that QOF has commodified the relationship between patients and general practice health staff. The commodification of health care brings an ethical 'paradigm shift from a profession to a market ethic' (Pellegrino, 1999, p. 246).

To commoditise the relation between patients and health care providers, a classificatory normative system has to be developed that clusters unique cases in order to provide a pattern against which the health staff's output can be measured, assessed or audited (Harrison, 2009, p. 191). This is what QOF basically does, supported by EBM at a high level of abstraction. Evidence-based medicine has the power to dissolve unique cases within population-based standardised categories, facilitating policy-makers to build a clinical governance framework. Hence, QOF's reductionist, 'tick box' approach to patient care is reframing human-related health conditions into 'QOFable' entities by selecting bits of complex realities and reifying them as commodities. These are then launched as a point-based system into the 'brokerage environment' of UK primary care, where points are converted into pounds.

The phenomenon of reification is at the basis of commodity-structure, since, according to Lukács (1971, p. 83), the commodity has a 'phantom objectivity' derived from the relation people assume with 'the character of things'. The commodity 'acquires an autonomy that seems so strictly rational and all-embracing as to conceal every trace of its fundamental nature: the relation between people' *(ibid)*. Thus, QOF distorts this 'fundamental nature' since it overrides (and/or substitutes) the patients in this relational process, their body biomarkers (level of cholesterol, haemoglobin A1c, proteinuria, blood pressure, FVE 1 [Forced Expiratory Volume in One Second], etc.) or disease conditions (breathlessness score check, feet check, eye-check) becoming token-information. This token-information is reified as a commodity to be first stored (alienated) in computer hard driver backups to be later traded (exchanged) with a third part within a bio-managerial 'quality' framework.

Hence, in its extreme form, the patient's body has become a mining-landscape, the locus of exploitive, lucrative enterprise. Within this the most profitable patients are those with multiple-comorbid disease profiles, primarily elderly patients (Boyd et al., 2005). This has a symbolic parallelism with a recent trend in body parts commodification, a process whereby 'the human body has attained medical and commercial value as a mine for spare parts for research and as a therapeutic tool' (Lock & Nguyen, 2010, p. 208).

The parallelism to the body-mining enterprise in QOF refers to extraction of token-information (through urine, blood, questionnaires) about patients' biomedical parameters within a standardised quality framework. The QOF scheme as biomedical technology is a 'mode of ordering' general practice in a way that frames human beings as a standing-reserve' (Heidegger, 1977, p. 20). In this commodification context, QOF sets a challenge to UK general practice: can it simultaneously be a place of health care and healing activities and of profit-making business enterprise, and, if so, how? (Pellegrino, 1999).

Seeding a commercial model of care in general practice

What QOF has done with this commodification process is to insert a foreign body into the heart of the UK's public primary care services: a commercial type of medicine (Rylko-Bauer & Farmer, 2002). The idea of a market-driven health system has systematically been put forward by different UK governments (Hunter, 2011) and QOF represents a policy initiative that has further advanced the business model concept into GPs' mind-sets:

> ***GP5:*** *Well, if you don't do the QOF that's what you're doing…you're doing the work…but accepting the fact that you don't get paid for it…you know…if you were…a private doctor…and somebody came in with a chest infection…hmm, but you also have to do their blood pressure to get paid by the insurance company…otherwise you wouldn't get paid anything at all…you would do the blood pressure, wouldn't you?*
>
> ***AHN:*** *Of course…*
>
> ***GP5:*** *If you were a private doctor, and that's the only way the insurance company would pay you…you're not allowed to bill them for a chest infection without a blood pressure…so <u>you would do it</u>…because that's…that's how it works! QOF is a bit like that...*

The phrase *'because that's how it works…QOF is a bit like that...'* reinforces QOF's similarities with the business model of medicine. This commercial model of health care is 'primarily or solely regulated by the rules of commerce and the laws of torts and contracts rather than the precepts of professional ethics. Profit-making and pursuit of self-interest will be legitimated' (Pellegrino, 1999, p. 252).

The QOF monetary scheme depends on the moral integrity of practices' professional staff, since they are the ones who feed the computers with QOF requirements. Consequently, the system is quite open to data manipulation or the use of 'ethically dubious methods' for

making the QOF work for the GP practices, as presented in Chapters Six and Seven. Despite the concerns of being caught by an audit process, money is a potent driver that cannot be easily ignored. This naturally produces a conflict of interests:

> *'Definitely, I mean…I think…hmm…I guess it depends on the…person…that's kind of…doing it as well…because I think…hmm…I mean…the money inside of it is important because that's how the practice is getting some of the funding and things. So, from that point it's important…but then there's potential for conflict of interest, really…because…you know, if you can…hmm…I guess it all comes to honesty ((slightly laughing)) and integrity and things…and it's important because you could be…recording things that you've not done'.* [GP9]

This commercial medicine is not only influencing health staff interactions with patients. Similarly, it predominates in the surgery backstage as in the case of practice meetings where, consequently, other important clinical issues may be put aside, particularly as practices reach the last four months of the QOF financial year:

> ***GP8:*** *It's just the "having to do it"…I mean it's…you obviously, to get…to get the money you need to do it…and for the practices…to make a profit they have…they have to do QOF…it's…a considerable chunk of their income, isn't it?*
>
> ***AHN:*** *Yeah…*
>
> ***GP8:*** *So, you have to do it, so, I guess is this "having to do it"…and the fact…you know…you're sitting in meetings…like today…there were loads of important things to talk about and we actually ended up talking about… you know…QOF and…what can be done…I don't know…*
>
> ***AHN:*** *So, it predominates…*
>
> ***GP8:*** *…It's just kind of…adding more and more pressure at the end of the financial year, it just dominates, the next three months or two months…all we're going to talk about is QOF, QOF…*
>
> ***AHN:*** *QOF…I should be in one of these meetings…*
>
> ***GP8:*** *Yes, you should actually…because Dr 'GP' does the…you know…"this is where we're at; this is what is predicted; this is where we're going…if we don't improve things"…"How*

can we encapsulate these mental health patients?" You know, that's the kind of things [the GP] *does…*

The above dialogue reflects the perverse nature of the QOF incentive: '*having to do it'* for monetary reasons. Consequently, QOF prevails at practice meetings and managerial levels by focusing on 'encapsulating' strategies to overcome difficult 'missing patients' or target conditions. Thus, the general practice discretionary spaces narrow at both consultation and managerial levels as pressure increases towards the end of financial year (Figure 5.5).

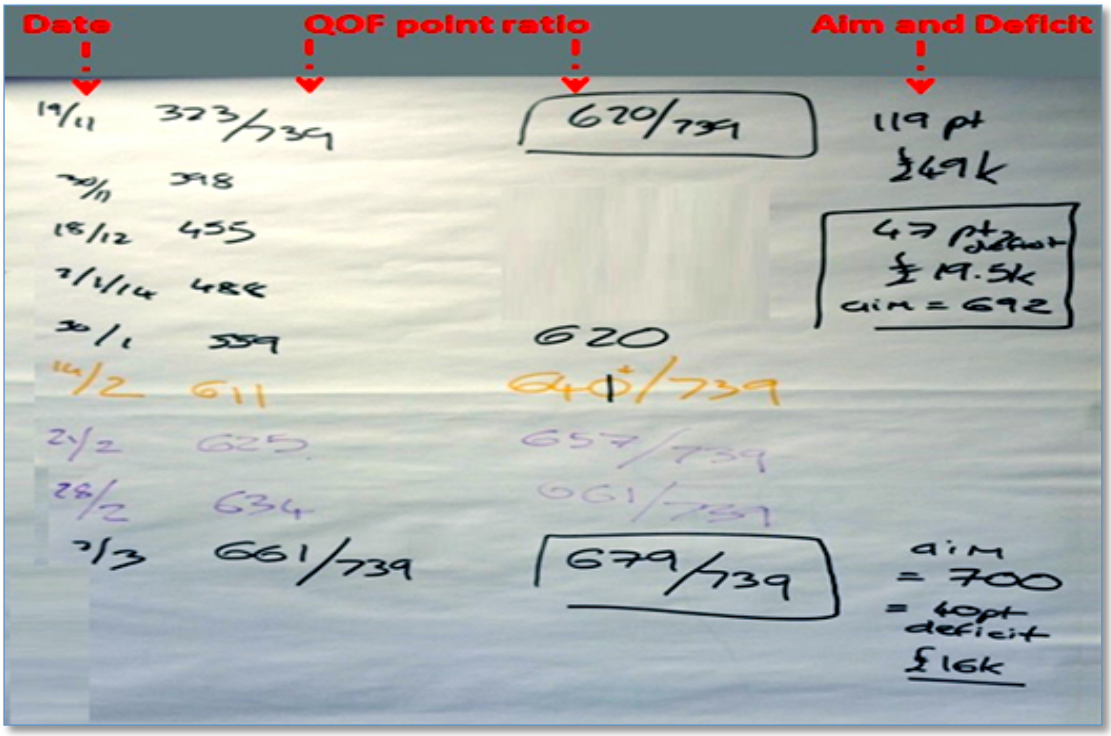
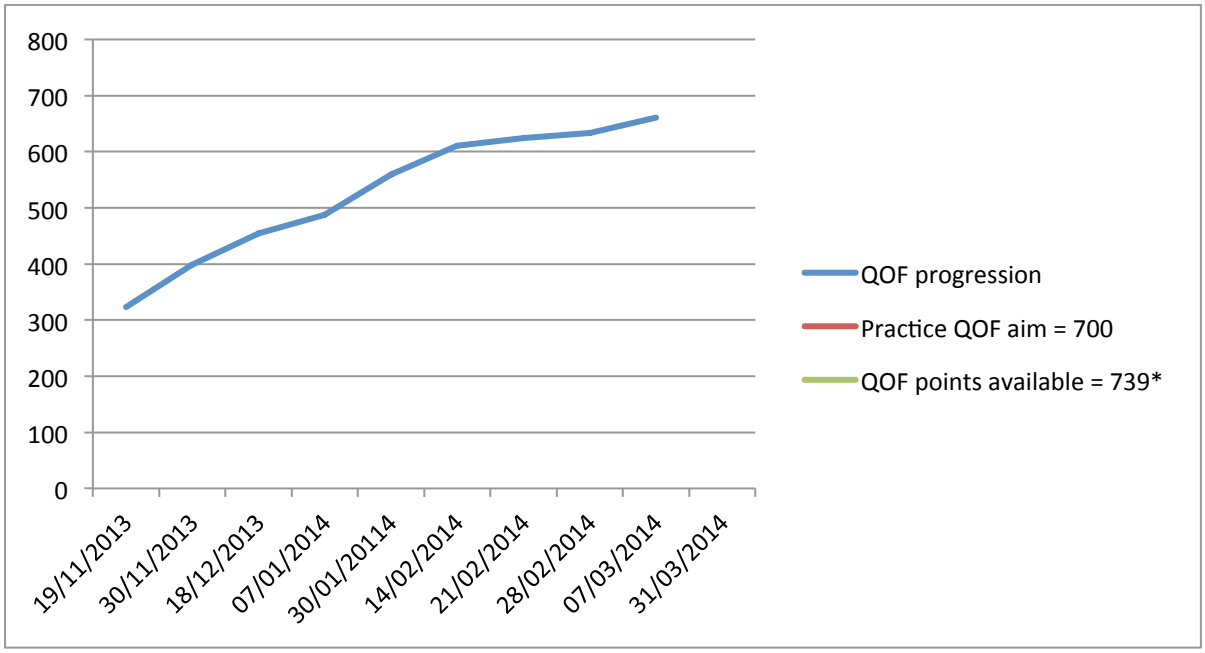


Figure 5.5. Evolution of points achieved, changes in the QOF aims, and potential losses from mid-November until the end of financial year (31/03/2014).

Figure 5.5 is the result of a series of practice meetings in which the practice QOF team had plotted the QOF progression from November until the end of financial year. To some extent, it is possible to have a sense of the atmosphere of such meetings and how QOF predominates during meetings discussions, as mentioned by the GP8.

Based on the above available data, a graph was built on QOF points' progression from November 2013 to March 2014. Graph 5.1 indirectly portrays the effort needed to reduce the gap from November to the end of March: on 19/11/2013 the practice team had 43.7% of the total amount of QOF points and they managed to increase to 94% by the end of financial year

(this 94% is not the final result, which means that they might have even reached near to 98%, as in previous years). Consequently, QOF really drives practice behaviour from December to March, creating an atmosphere that, to a certain extent, distorts the services offered.



Graph 5.1. QOF points' evolution from November 2013 to March 2014. *In spite of the 2013/14 contract contained 900 QOF points, the clinical part and some of the public health sub-domains (that practice could aspire to) comprised 739 QOF points. This difference in QOF points refers to other non-clinical targets such as patient experience and some public health sub-domain, i.e. quality and productivity indicators.

Figure 5.5 and Graph 5.1 illustrate how QOF, instead of being perceived as a reward instrument is seen as a penalty mechanism. That is the reason why the practice team refers to patients not just in terms of how profitable they are for the practice, but similarly how much the patients cost the practice. The attitude or effort now is to try to reduce the amount that is going to be lost. For instance, in the column 'aim and deficit' of Figure 5.5, the initial projection was that the practice had a deficit of 119 points, which would imply 49 thousand pounds loss; then practice managed to reduce it to 19.5 thousand pounds (47 point deficit), to finally reach a reasonable or acceptable loss of 16 thousand pounds by not getting the remaining 39 points. Hence, there was a perception of QOF as a practice funding control mechanism by some GPs, as in the following quotations:

> *'In my view,* [QOF] *is more of a…funding of practices to cost limit…the amount of money that the practices get, because they've increased the targets…and some of them are…not realistic targets, in my view…to manage…so, that means if we don't complete a hundred per*

cent…we won't get the funding…so, it's a way of…managing…finances to practices…' [GP12]

[or]

'Therefore, you're just playing catch up for the rest of the year and it is deliberately done in that way, so, that we get paid less, so, we don't achieve our targets…it's…it's just a soft way of getting back money from us'. [GP4]

The flip side of moneymaking is risk-taking or financial loss. These utterances mean that the business model of today's UK primary care has moved a step further. The QOF scheme is forcing a commercially minded medicine geared by a profit-making agenda. Despite general practitioners traditionally being independent contractors, they have behaved more as salaried professionals, securing a good wage and at the same time protecting their autonomy from NHS bureaucratic structure (Lewis, 1998).

However, since the 1990s the UK government has been trying to recast GPs as entrepreneurial, business-minded physicians and has been challenging GPs' self-employer status and *for* service contract arrangement *(ibid)*. It seems that QOF has further developed the trend of privatising the NHS (Hunter, 2011), by fostering a more commercially driven medical approach within doctor-patient relationship.

Boosting the NHS internal bioeconomy

In Chapter Four I discussed Foucault's concept of governmentality and the importance of a biopower framework for controlling/disciplining the two poles of the population (biopolitics) and individual bodies (anatomopolitics). Nevertheless, the QOF commodification process adds another dimension to economies of vitality. As Nikolas Rose (2006, p. 6) points out, today:

> Novel links have formed between truth [biomedical knowledge] and capitalisation, the demands for shareholder value and human value invested in the hope for cure and optimality. A new economic space has been delineated – the bioeconomy – and a new form of capital – biocapital.

The QOF commodification process has produced or framed human beings in terms of their bio-values that need to be extracted through urine, blood, and questionnaires. The NHS

internal bioeconomy has become animated via general practice surveillance and monitoring systems that prompt managerial, administrative and health staff to chase patients (Checkland et al., 2007), as well as to focus their attention on QOF points and practice monetary rewards, as discussed in Chapter Four. This produces a cascade of consumption of biotechnologies, which boosts a whole biomedical complex industry in the UK (Rose, 2006). This link between government and biomedical complex industry can be read in Tony Blair's speech to the 'European Bioscience Conference in Lisbon, 2000: "Biotechnology is the next wave to the knowledge economy and I want Britain to become its European hub"' (Rose, 2006, p. 35). Thus, rather than seeing QOF commodification as an isolated phenomenon I understand it as connected with the UK's macro-socioeconomic politics and power.

The QOF business model can collide with patients' agendas, altering the original relationship between patients and their health care providers. Firstly, by labelling more patients as needing QOF related medical interventions it increases the practice economic gains (Chapter Eight); secondly, if the number of patient 'informed' dissents increases (i.e. exception reporting) it might draw the attention of the commissioning group overlooking practice overall performance. Consequently, transformed into commodities, patients are chased and cajoled into GP surgeries to be checked and reviewed, in order to maintain the practice's expected budget. The following quotation illustrates this kind of distortion:

> *'Hmm...sometimes…it's a benefit to the patients, but sometimes you feel like…you're sort of chasing patients, <u>just</u>…to reach a target, <u>just</u> to tick a box, you know, you could have… hmm…very elderly patient who doesn't want to come in and you phone them and try to get them in…hmm…In the other way, it is a bo[nus], benefit, because there's certain areas that you need to look at for each chronic disease…hmm…but…a sort of systems in place to have regular recalls for these patients, which might not happened before...'* [MF5]

The intensity of this chasing process can sometimes be very intrusive and disturbing for patients, as highlighted by another managerial member of staff:

> *'It's got to the point of harassment for the patients because you* [the doctors] *keep telling me that we have to achieve these points and, if we don't, we're not a good practice, right…so to do that we have to keep nagging the patients, and we've had patients* [who] *said: -"Would you leave us alone? I'm not having that done!"…cervical cytology, for example. A lot of women* [said]: *- "I'm not having the smear" – "- But it's important…" –"I'm not having it…leave me alone!". And we've literally had them saying that. There're others who said: -*

> *"Great, it's wonderful!"…hmm…-"Thank you very much, I've never thought about it."…Fine, you know, they are all right. But there's a lot of stuff where people don't see the value of it…you know'.* [MF4]

This context is relevant, because it shows 'the ways in which the living character of human beings, and indeed of other living beings [i.e. genetic modified organisms] is being harnessed by biocapital' (Rabinow & Rose, 2006, p. 199). The process of transforming patients into commodity-bearers distorts the relationship practices have with patients, some of which will be tackled in Chapter Six.

The fact that 'people don't see the value of it' emphasises a hegemonic view of what constitutes quality health services, which in the case of QOF is framed by a biomedical approach. This reinforces that the commodification process is not based on its 'use value' ('material goods which are useful to human beings' – Timmermans & Almeling, 2009, p. 23), at least from the point of view of patients. Conversely, the QOF commodification process is based on 'exchange value' that was politically established within the artificial internal health market. This is so factual that in our current era of 'EBM', QOF was introduced without a proper pilot or control group (Steel & Willems, 2010).

As our conversation progressed, the managerial staff member remarked that this chasing attitude is not only intrusive to patients, but is leading to a process of draining NHS resources and medicalising society as a whole even more:

> *'…. It's taken all these blood tests of people, and say: -"You should be on statin". Who said you should be on statin? You lot can't even agree! Every time I read the* [news] *paper some of you are saying: "-You must be on statin" and others are saying: "- You shouldn't be on statin," and others are saying "There's even contradiction"…and I'm not even a doctor! But I'm sufficiently known to say: -"I'm not taking it" - if they ask me to take them - because* [it] *makes your mind up, you know, if the evidence isn't absolute, you know…hmm…it just happens…I'd rather try some natural, you know, health based approaches than actually put my trust in Smith-Glaxo or whatever, who are making billions of pounds out of the statins medication…and so on and so forth…you want to medicate everything you lot!'.* [MF4]

The above utterance by a managerial staff member concerns QOF's potential for medicalising asymptomatic people and its susceptibility to the power of pharmaceutical industry influences on QOF indicators criteria, as discussed in Chapter Eight.

The link between QOF and macroeconomics of pharmaceutical industry or business is not a conspiracy theory, since QOF indicators are based on clinical biomedical conditions for defining a quality of care that usually requires some sort of drug intervention. Most QOF domains focus on individualised preventive actions via consumption of biotechnologies and drugs. Polypharmacy has become the norm: from 2004 to 2011 'prescriptions for statins doubled, for angiotensin converting enzyme inhibitors (for blood pressure control) and diabetic drugs nearly doubled, for antidepressants rose 60%, and for steroid inhalers rose 30%' (Spence, 2013, p. f1498). Despite this increase in medication usage, cardiovascular mortality has not diminished during the QOF era (Kontopantelis et al., 2015).

QOF and the high-risk strategy

Most QOF clinical domains entail preventive actions based on what Foucault has described as the leper model (Chapter Four). This model has a binary (yes/no) classificatory approach, which selects those who need biomedical intervention. In public health this is known as high-risk strategy, because it separates those with a high probability of suffering an adverse event from those with habitual risk (Rose, 1985).

Through QOF, policy-makers have favoured the high-risk strategy, which individualises and capitalises disease preventive actions through the consumption of biotechnologies rather than fostering a population-based approach aiming at tackling the social determinants of health (Bayer & Galea, 2015). For instance, while the government has invested billions of pounds in this quality scheme, social inequalities in the UK have increased (Wilkinson & Picket, 2010). This is recognised as a major source of health and social problems (Stuckler & Basu, 2013). According to the Institute of Fiscal Studies (Belfield, Cribb, Hood, & Joyce, 2014, p. 3):

> Over the last half century, the gap between rich and poor has risen. This can be largely attributed to the sharp rise in inequality during the 1980s, as the incomes of those in work pulled away from those of the rest of the population and as high earners saw the fastest growth.

In terms of population benefit, the high-risk strategy offers little impact on disease mortality, since the high-risk group represent a tiny portion of the population (Rose, 1985). Thus, despite being intuitively adequate for both health professionals and patients, as well as being cost-effective, from the population perspective it is disappointing. This is because most cases (i.e. heart disease mortality) are produced by people with moderate to low-risk, since they

comprise the majority of the population/disease spectrum. For instance, women aged 40 years old or greater have a higher risk of Down syndrome babies, but they only contribute 13% of cases. On the other hand, women aged 30 years old or less contribute almost half of the Down syndrome babies. Despite individually having low-risk, they represent a bigger group (Rose, 1985).

However, experts and researchers in public health 'solved' this paradox of prevention by reducing cut-off points for defining what constitutes 'high-risk'. For instance, recently the National Institute for Health and Care Excellence has reduced the prescribing threshold for statins from a 20% risk of 10-year mortality projection to a 10% risk (NICE, 2014). This trend has the effect of converting more asymptomatic people into a 'sick' state, as well as medicalising more since it establishes hard-to-reach targets for cholesterol, diabetes (Hb1Ac), blood pressure, obesity and the like (Montori, Isley, & Guyatt, 2007).

The process of reducing the cut-off point for defining an intervention increases the number of people needing medical interventions, and consequently, the disciplinary technology required for that. This disciplinary technology seeks to assure a continuous surveillance system, such as in the plague model discussed on Chapter Four. Thus, QOF is an example of Panopticism, which allows for continuous biomedical interventions through monetary incentives that is simultaneously an individualising and totalising technology.

Playing with QOF cut-off points and thresholds: expanding the commodification process

The strategy of manipulating cut-off points can be seen in some QOF clinical indicators. This process occurs by setting targets with reduced treatment cut-off points (considered as optimum treatment) and/or increasing the upper end range for a target. For example, in 2013/14 this strategy was clearly used in regard to hypertension: QOF has tightened the hypertension target by placing 50 points to a 'newly' introduced QOF hypertension indicator (HYP003 – requiring the blood pressure to be below 140/90) against 10 points for HYP002 – requiring blood pressure to be below 150/90 (Figure 5.6). This leads to the inclusion of more patients under a tight blood pressure control.

Hypertension (HYP)

Indicator	Points	Achievement thresholds
Records		
HYP001. The contractor establishes and maintains a register of patients with established hypertension	6	
Ongoing management		
HYP002. The percentage of patients with hypertension in whom the last blood pressure reading (measured in the preceding 9 months) is 150/90 mmHg or less	10	44–84%
HYP003. The percentage of patients aged 79 or under with hypertension in whom the last blood pressure reading (measured in the preceding 9 months) is 140/90 mmHg or less *NICE 2012 menu ID: NM53*	50	40–80%

Figure 5.6. QOF hypertension indicator targets, points and range of achievement. Source: BMA, NHS Employers, & NHS Commissioning Board, 2013.

By incentivising reduced cut-off points, QOF significantly increases the number of target people needing medical intervention, since it works at the population level or practice catchment area. This process increases the number of laboratory tests, follow ups and drugs being prescribed to reach a lower blood pressure threshold target within a cohort of hypertensive patients. Consequently, the trend is the increase in consumption of existing biotechnologies and drugs (expanding the use of existing drugs which do not require further research cost for the pharmaceutical industry), but simultaneously drains NHS resources (Spence, 2013).

The QOF indicators for diabetes are another example of how policy-makers have played with cut-off points and the standard upper-end threshold. One of the criteria for a good diabetes control is through monitoring the level of haemoglobin A1c (HbA1c). Table 5.1 illustrates the fluctuation in HbA1c targeting and the increase in quality standards by expanding the upper range for maximum points. This leads to more patients on tighter diabetes control regimens and increase in medication usage.

Table 5.1. Diabetes level of HbA1c in the previous 15 months* organised by points' allocation (P), range of achievement (R), and QOF contract year.

QOF year	2004/05		2006/07		2009/10		2011/12		2013/14	
HbA1c target mmol/mol (%)	P	R (%)	P	R (%)	P	R (%)	P	R (%)	P	R (%)
≤ 53 / (7.0)					17	40 - 50				
≤ 59 / (7.5)	16	25 - 50	17	40 - 50	-	-	17	40 - 50	17	35 - 75
≤ 64 / (8.0)	-	-	-	-	8	40 - 70	8	40 - 70	8	43 - 83
≤ 75 / (9.0)	-	-	-	-	10	40 - 90	10	40 - 90	10	52 - 92
≤ 86 / (10.0)	11	25 -85	11	40 - 90	-					

* QOF 2013/14 reduced the length to reach the target to 12 months. Sources: compiled from HSCIC 2005; HSCIC 2007; HSCIC 2010; HSCIC 2013; and HSCIC 2014b.

Table 5.1 shows that in 2009/10 QOF introduced three tiers for HbA1c levels, placing more points on lower cut-off points (≤ 53/7.0% = 17 points) inducing practitioners to be more aggressive in treating their diabetic patients. In 2011/12 this threshold was augmented as diabetes tight control (HbA1c below 6%) increases patients' mortality rate (Gillam & Steel, 2013; The ACCORD Study group, 2011, p. 818). However, in 2013/14 QOF expanded the upper limits in all three tiers. Once more policy-makers allocated more QOF points to lower bands of HbA1c: 17 QOF points to HbA1c≤ 59mmol/mol and eight QOF points to HbA1c ≤ 64mmol/mol. This meant that most diabetic patients had their levels of HbA1c geared towards the bottom end of HbA1c range, potentially increasing the use of medication and side effects (hypoglycaemia with hospitalisation). Nonetheless, the benefit of such intervention remains controversial. The American Association of Family Physicians suggests that levels of HbA1c from 8% to 9% are more appropriate (Shaughnessy, Erlich, & Slawson, 2015).

In the last decade, the UK has experienced a 60% rise in diabetes cases, accounting for '10% of the NHS drugs bill' as 'nearly £869m was spent on drugs, including insulin and metformin, marking a sharp rise from the £514m being spent a decade ago' (Gallagher, 2015). As Geoffrey Rose (1992) highlights some of the weaknesses of the high-risk preventive strategy: (a) 'prevention becomes medicalised'; (b) 'success is only palliative and temporary'. This means that it needs a constant maintenance of services by not addressing the diseases' root cause (i.e. socio-economic health determinants); (c) 'the strategy is

behaviourally inadequate' (advices on life style changes are shaped by people's peers and social environment); (d) 'it is limited by poor ability to predict the future of individuals'. In other words, it creates uncertainties for the individuals receiving the preventive intervention since patients are pooled in a risk-benefit population intervention, further discussed in this chapter (Rose, 1992, p. 48). However, this is 'music to the ears' of the pharmaceutical industry and its financial future market shareholders scheme since it generates a continuous market for biotechnology consumption.

Commodification and future markets: the rise of speculative medicine

As Nikolas Rose (2006) highlights, currently biomedicine does not seek just to restore patients' biological normality, but rather aim at its optimisation by acting in the present. The benefit of such intervention is to be harvested in the future. For instance, rather than improving the diabetic disease symptoms and patients' perceived well-being, it aims at reducing the chances of future damage, such as blindness, renal failure, and heart disease. The measurement and control (usually through medication) of biomarker-forecaster parameters levels (haemoglobin A1c, cholesterol, etc.) have become paramount in this biomedical model, as materialised by the boldest health quality scheme in the world: QOF.

However, as evidence for this health optimalisation derives from large population-based studies or their meta-analyses, the current preventive medical model entails uncertainty about who will benefit from the medical intervention (probabilistic/empiricist reasoning) (Harrison, 1998). Therefore, underpinning this preventive strategy is an inductive reasoning, which assumes that what holds for the sample (clinical trial or cohort study's population) equally holds for the whole population, just because that particular individual before the doctor displays some biometric resemblance with the sample population used in a clinical trial (Whitehead, 1967).

Consequently, this preventive strategy reinforces the concept of a socioeconomically decontextualised, collective, and universal body that can be standardised for biomedical interventions (Lock & Nguyen, 2010). However, individual patients (and their doctors alike) tend to have deterministic/realistic reasoning as they experience the effect of medical practices and interventions in their daily lives and bodies. In other words, they use the 'A' leads to 'B' linear causality model.

Probabilistic reasoning based on empirical studies generates specific statistical numbers. For instance, perhaps the most used statistical number by general practitioners is the numerical concept of Number Needed to Treat (NNT): the number of people needed to receive the intervention during a certain period of time (five or 10 years) to prevent one event (i.e. mortality due to myocardial infarction - MI). Suppose that the NNT is 100, meaning that 100 people should be treated during 10 years to prevent one MI. From the patient's perspective, each one of them thinks he/she is the 'chosen one' amongst 100 because each of them experiences in his or herself the medical interventions of this speculative preventive medicine (deterministic/realistic reasoning).

This context helps to create the paradox of popularity: 'the greater overdiagnosis and overtreatment, the more people there are who believe they owe their health or even their lives' (Raffle & Gray, 2007, p. 68) to medical interventions, creating a vicious circle of medicalisation. The typical example is the use of statins for reducing cholesterol in primary prevention, that is, patients without cardiovascular disease (CVD) such as coronary heart disease (CHD). These asymptomatic people can now be converted in high-risk patients by means of several risk calculators scoring devices.

The QOF cardiovascular indicators for primary prevention (CVD-PP) are shown in Figure 5.7. Firstly, it presents the imbalance between QOF points' allocation and workload, since it is much easier to prescribe statins using computerised templates than to motivate people to change their behaviour. This highlights the role policy-makers have in producing the 'exchange value' in the commodification process. Secondly, it shows the transformation process of asymptomatic people into 'high-risk' group: those '*who have a recorded CVD risk assessment score (using an assessment tool agreed with the NHS CB) of ≥20%*'. The recommendation is that these patients should be using statins for preventing CVD.

Cardiovascular disease – primary prevention (CVD-PP)

Indicator	Points	Achievement thresholds
Ongoing management		
CVD-PP001. In those patients with a new diagnosis of hypertension aged 30 or over and who have not attained the age of 75, recorded between the preceding 1 April to 31 March (excluding those with pre-existing CHD, diabetes, stroke and/or TIA), who have a recorded CVD risk assessment score (using an assessment tool agreed with the NHS CB) of ≥20% in the preceding 12 months: the percentage who are currently treated with statins *NICE 2011 menu ID: NM26*	10	40–90%
CVD-PP002. The percentage of patients diagnosed with hypertension (diagnosed on or after 1 April 2009) who are given lifestyle advice in the preceding 12 months for: smoking cessation, safe alcohol consumption and healthy diet	5	40–75%

Figure 5.7. CVD-PP001 receiving 10 QOF points against 5 QOF points for CVD-PP002, which aims at lifestyle changes such as smoking cessation and healthy dietary advices. Source: BMA, NHS Employers, & NHS Commissioning Board, 2013.

According to QOF 2013/14 guidance, general practice can use three different CVD risk-assessment scores (Framingham, Joint British Society 2 (JBS2), and QRISK®2). Nevertheless, the two first devices are known to overestimate the risk, as stated in QOF 2013/14 guidance:

> Framingham and JBS2 are based on the American Framingham equations. These equations are of limited use in the UK because they were developed in a historic US population. The equations overestimate risk by up to 50 per cent in most contemporary northern European populations, particularly for people living in more affluent areas and underestimate risk in higher risk populations, such as people who are the most socially deprived. (BMA, NHS Employers, & NHS Commissioning Board, 2013, p. 156)

This situation of overestimation manifested during my fieldwork when a 50-year old male patient was re-issued statins[3], even though he had given up smoking. After the patient left the consulting room I asked the GP why he had written the patient a statin prescription, when he quitting smoking had reduced his risk of CVD. The GP, then, showed me the patient score risk by using QRISK®2 calculator revealing 11.87% CVD mortality rate in 10 years projection (Figure 5.8).

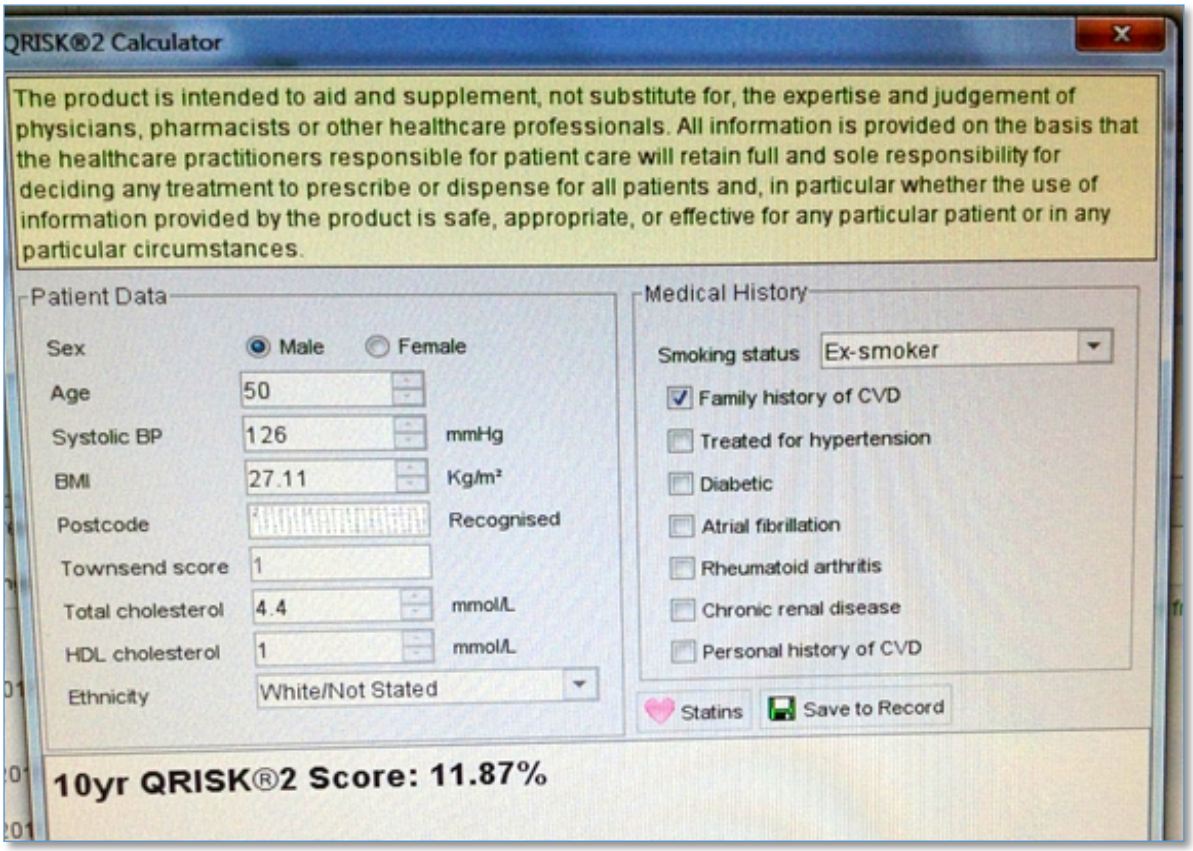


Figure 5.8. QRISK®2 scores of an asymptomatic 50-year old male, ex-smoker, with no use of hypertensive medication.

The above result came with a surprise, but the GP said that they usually check with the CVD risk calculator (JBS2) as well. When the GP changed to the other risk assessment it showed a higher score: 25% to 37.49% probability of having CVD mortality in 10 years (Figure 5.9).

[3] Statins comprise a class drug that reduces the level of cholesterol by inhibiting an enzyme HMG-CoA. This enzyme is a key element in cholesterol production (Wikipedia, 2015). Since high levels of cholesterol have been associated with cardiovascular disease, statins have gained momentum as preventative drug either in secondary prevention (amongst high-risk groups, i.e. patients with established cardiovascular disease) or in primary prevention (amongst patients without an established cardiovascular disease, but who have a high-risk profile due to a combination of factors such as age, smoking status, diabetes, levels of cholesterol, etc).

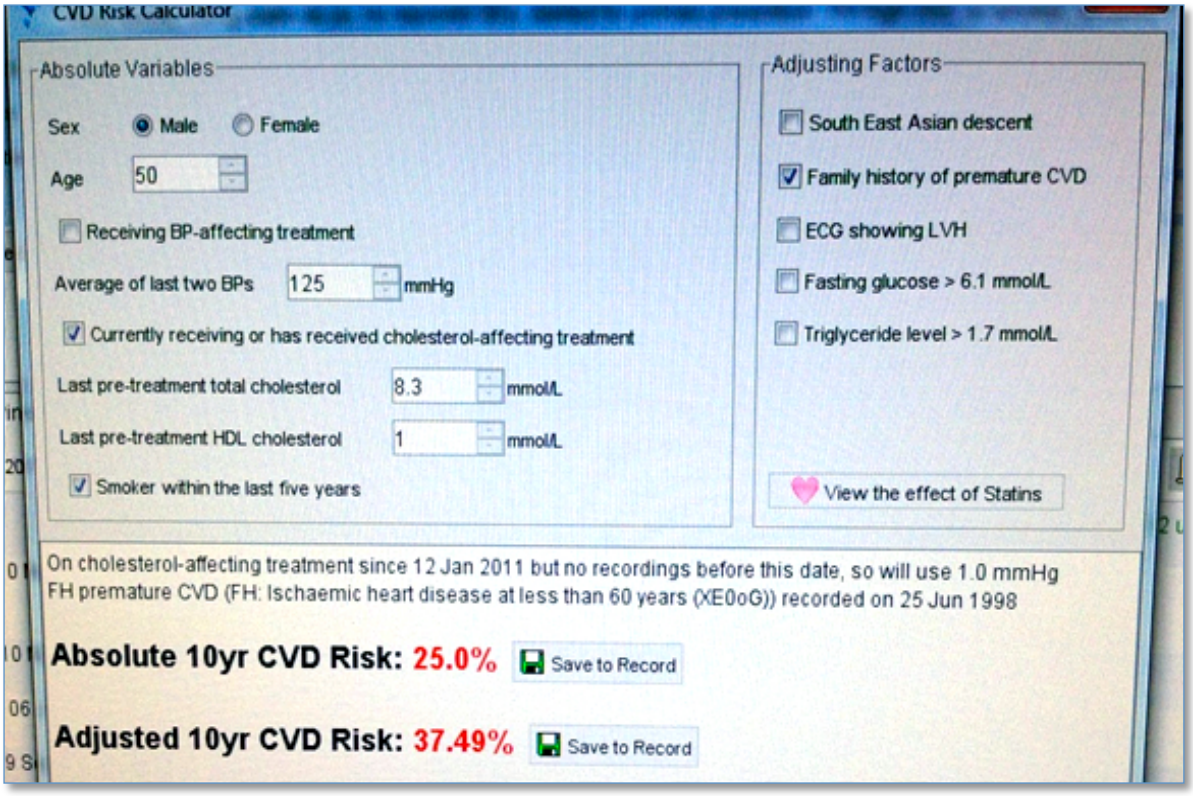


Figure 5.9. CVD risk score of an asymptomatic 50-year old male, ex-smoker, with no use of hypertensive medication (this calculator uses the average blood pressure).

This example shows how criteria might vary within the same patient. Thus, depending on the risk assessment tool, clinicians could label more or less individuals as needing statins. The QOF scheme is based on a disease model, the more conditions attached to a patient the more the chances of increasing practices' profitability, as discussed in Chapter Six (p. 150). Therefore, it should not be a surprise if some practices adopt a risk calculator device, which labels more people as in disease or risk carrier by labelling them as sick and hence needing statins.

Regardless of the device chosen to make these risk calculations, by establishing a 20% or greater risk of having a cardiovascular event, this group of people has been promoted to a high-risk group purely through population health modelling (Bauer, 2013). This configures an example of primary prevention, since they do not have clinically established CVD. This anticipatory strategy of acting on healthy people is strengthening a speculative preventive medicine approach based on proliferating risk device predictors (i.e. clinical decision-support software, or web-based self-tests) within which individuals have to adjust themselves 'to routinized likelihoods, hedged bets and probable outcomes' (Adams, Murphy, & Clarke, 2009, p. 247).

In the speculative preventive medicine all 'numbers' (potential risks) discussed in prevention are anchored at the population rather than the individual level. Despite intervening on individuals, the public health objective is to achieve an effect at population level such as a reduction in the cardiovascular mortality rate (at least, this is the hope of policy-makers). This means that the 'success' of the intervention depends much more on the capitation and compliance of patients with similar risk levels rather than the treatment of an individual isolated case. Policy-makers have aimed to enhance patients' 'compliance' by attaching money to individual indicators, prompting general practice teams to chase patients, calculate their cardiovascular risk, and prescribe statins.

However, this high-risk strategy produces uncertainty about who individually will benefit from it (Rose, 1992). For any particular person, the treatment means that he or she must enrol in what is effectively an unbranded 'trial' in order to achieve the desired population benefit through a sum of individualised interventions. The patient is caught in a 'sea of uncertainty', which is seldom discussed in depth, since, for that particular person, doctors know nothing about the effect of the intervention (i.e. population studies have anonymised the asymptomatic person in front of them). This anonymisation cannot be overcome by taking a patient-centred approach, even using information techniques for conveying probability (Spiegelhalter, Pearson, & Short, 2011). Furthermore, the monetarily built-in conflict of interest within the QOF scheme erodes the patient-centred approach.

Doctors usually tend to speak more positively to their patients in terms of 'Mr X your chances are...' but forget that EBM operates at a very abstract mathematical realm of population-based study trials, which know nothing about Mr X., making it quite impossible in the case of preventive measures to transfer results to that particular person. Nevertheless, doctors have gone through an acculturation process via training programmes (Roland, 2004), whereby abductive reasoning has become normalised as 'best practice' backed by, and incentivised to conform to quality framework schemes within which the QOF stands as an example (Checkland et al., 2008; Campbell et al., 2008). Therefore, when come to sharing information and decision-making within the consultation, practitioners are more likely to be assertive in terms of drug benefit.

The speculative preventive medicine manifests itself through templates employed to inform individuals of their future adverse outcomes. This is exemplified in QOF CVD-PP indicators (QRISK2® template), QOF Arthritis Rheumatoid indicators (a ten-year predicted absolute fracture risk can be calculated using FRAX2) or even the use of isolated biomarkers

such as HbA1c to predict micro-vascular complications. In this regard, Foucault is illuminating as he explains why certain approaches to social issues are encapsulated by the State:

> What we have to realise is precisely that there was no such thing as a bourgeoisie that thought that madness should be excluded or that infantile sexuality had to be repressed; but there were mechanisms to exclude madness and techniques to keep infantile sexuality under surveillance. At a given moment, and for reasons that have to be studied, they generated a certain economic profit, a certain political utility, and they were therefore colonised and supported by global mechanisms and, finally, by the entire system of the State. (Foucault, 2003, pp. 32-33)

Hence, it could be argued that QOF's concept of disease prevention has strengthened a high-risk strategy not because the government is really interested in people's health, but because it produces 'certain economic profit, a certain political utility' for the UK bioeconomy, i.e. the whole sector of biomedical technologies and the pharmaceutical industry.

CONCLUSION

This chapter has discussed two intertwined issues regarding the theme of commodification in general practice. Firstly, it addressed the process of services commodification as a 'package of body parts or health conditions' to gradually explore the phenomenon of patients' commodification through their bodily by-products. These by-products, such as biomarkers in urine (proteinuria), blood (cholesterol), blood pressure, body mass index (BMI) or score from questionnaires are converted into token-information to be traded within the NHS internal bioeconomy.

Secondly, it discussed how QOF has framed patients as possessing bio-values, being themselves a source of biocapital. This process intensified the capitalisation in the NHS quasi-market reality, clearly depicted by its 'criteria for reimbursement, and in general, their treatment of health and illness as merely another field for calculations of corporate profitability' (Rose, 2006, p. 11). This phenomenon of commodification and bio-capitalisation is in line with the government's aspiration for Britain to be a leader in biotechnology within Europe. In this context, QOF has stimulated a space for increasing the market of drugs and biotechnological devices.

Applied to the masses, QOF as monetary-incentivised ‘high-risk’ preventive strategy constitutes an example of a surveillance and disciplinary device. This makes it a primary source of overdiagnosis, and consequently overtreatment (Heath, 2013). This model of speculative medicine is more likely to label and treat healthy people through the spread of fear (Heath, 2011) and by challenging people's sense of self-security (Illich, 1976). Therefore, this approach to health prevention through a sum of individualised biomedical interventions, with an aim to reduce the burden of disease at the population level, is both ethically problematic and scientifically unsustainable (Heath, 2010).

The current prospect of health as a mere commodity resonates with the neoliberal approach towards the NHS with its emphasis on markets and competition, recently regarded as a failing bank needing continuously to be bailed out (The Lancet, 2013). Hence, primary health care in the UK has internally become a commercial enterprise. This might increase the chances of introducing some form of patients’ co-payment as a next step in the process of privatising the NHS, a process justified by a spurious discourse of austerity.

Chapter Six

QOF'S RULES: PLAYING THE GAME

This chapter examines some behavioural changes that have occurred in the general practice work environment as a result of the introduction of the Quality and Outcomes Framework. The QOF surveillance mechanism (Chapter Four) and the consequent intense capitalisation of general practice activities (Chapter Five) have had powerful influence in organising the working processes of general practice. Since QOF's inception, several interview-based qualitative studies have been carried out (Maisey et al., 2008; Campbell et al., 2008; Campbell et al., 2011; McGregor, Jabareen, O'Donnell, Mercer, & Watt, 2008), and at least three ethnographic studies have looked at different aspects of QOF.

The first ethnography, carried out in 2005/06 QOF contract year, has resulted in several papers encompassing professional motivation and control (McDonald, Harrison, Checkland, Campbell, & Roland, 2007; McDonald, Harrison, & Checkland, 2008); holism in general practice (Checkland et al., 2008); and QOF's impact on practice organisation and services delivery (Checkland et al., 2007; Checkland & Harrison, 2010). The second ethnographic study was conducted from 2007/08 (i.e. the 2006/07 QOF contract year). This ethnography looked at the effect of information and communication technologies such as Electronic Patient Records (EPR) on clinicians' consultation (Swinglehurst et al., 2011b). Two papers derived from this ethnography have relevance to QOF issues such as the use of templates in nurse consultation (Swinglehurst et al., 2012), and data quality production in general practice (Swinglehurst & Greenhalgh, 2015). The third ethnographic study explored the effects of QOF screening depression indicator among patients with chronic conditions (diabetes and coronary heart disease). The study combined observation of consultations, interviews of both health staff and patients, and a review of patients' records (Alderson et al., 2014). In the present chapter, I shall use some of these research findings to elucidate the impact of QOF on general practice.

Professional staff generally welcomed the first edition of the QOF scheme, meaning that general practice has finally moved forward towards an EBM model of practicing medicine. However, from the second edition (2006/7) onwards GPs became more sceptical about QOF's evidence-driven approach to health care:

> The introduction of new quality indicators in the second round, rather than being the "quiet evolution" described by some advisers to the scheme, was perceived as less legitimately evidence-based than the original targets…the first round indicators reflected established "best practice", whereas second round "QOF" indicators reflected more recent developments in research, and were less well known or accepted. (Maisey et al., 2008, p. 138)

Policy-makers original hope for QOF was that its embedded EBM model would drive general practice's 'quality' standards up, by reducing variability in the care of major clinical areas (Roland, 2004). Thus, underpinning QOF ideal was clinicians' compliance to a series of evidence-based guidelines, a kind of quality 'blueprint' for health professionals to deliver better care.

Moreover, this approach was in line with a political agenda of value for money, performance and outcomes (Pollitt, 1993), based on more accountable, auditable, measurable, objective, and standardised primary care services (Harrison, 2002). This has produced a strong clinical governance environment to which health professionals have to conform. For Timmermans and Almeling (2009) this institutional formalism can have constructive effects. For instance, they used Stinchcombe's metaphor of 'architectural blueprints' that resemblances 'clinical guidelines' as a positive example of formalisms:

> …That allow people from diverse crafts to get the job done, but which do not include every tiny detail needed to construct a building, as much of this information is based in building codes or construction techniques that do not need re-specification. Moreover, he [Stinchcombe] points to the flexibility of blueprints, noting that if contractors catch mistakes made by architects, they will ignore or improve on the blueprint - an example of the routine blurring between informal tinkering and formal abstractions. (Timmermans & Almeling, 2009, pp. 21-22)

However, QOF has stimulated a commercial type of medicine in general practice by commodifying its relationship with patients. McDonald et al. (2007, p. 5) have framed this as a "chaser" and "chased" type of relationship. Hence, the pay-for-performance has introduced a different element to the blueprint metaphor. For example, clinicians might judge that some of QOF indicators are inappropriate – i.e. 'mistakes' made by an architect while drawing a blueprint – but contrary to the builders, who might just 'ignore' it or be flexible in producing a solution, clinicians must follow QOF guidelines in order to generate their income. This is when guidelines become detailed prescriptive protocols. This kind of formalism (antonym to

informal or substantial reality) has the potential, according to Max Weber, to be associated with fraudulent or ritualistic behaviour (Timmermans & Almeling, 2009, p. 22).

Differently from an architectural blueprint's final result (i.e. a building), the QOF scheme is based on the production of patients' token-information as a 'commodity' to be exchanged, as well as criteria for ranking practices' quality standards of care. Nevertheless, QOF's virtual end products are a result of the practice team's behaviour. In fact, QOF generates a range of data production strategies and behaviours. In this chapter I explore some of the strategies in data production, which are one of the ends of the spectrum. The other end of this behaviour spectrum, gamesmanship, is discussed in Chapter Seven. Both behaviours represent the same facet of this biomedical technology. As QOF data production represents a plurality of strategies and behaviours, I tried to give it an organised shape based on their commonality or resemblance. Similarly, I framed it in a gradual progression or sequential order: from QOF planning strategy to playing QOF as a 'game'.

The first part of this chapter discusses an aggregate of strategies within which practices are deploying their healthcare staff and managerial team in conformity with QOF requirements to maximise the chances of getting most of the QOF points available. The second part of this chapter discusses how practice teams make QOF work and play the 'QOF game' with consequences for both patients' access to health care provision and health professional behaviours. This is particularly true as practice teams reach the end of financial year, producing a sort of 'Mad March Hare' phenomenon.[4]

PREPARING FOR THE QOF GAME

In spite of not having the opportunity to attend the practice 2013/14 QOF planning meeting, I was allowed to attend the QOF planning meeting for 2014/15 as practice 'B' prepared itself for a new QOF financial year. Being the QOF an important financial resource, carefully

[4] This idiomatic expression was introduced to me in the 'Amigos' international student-meeting group in Durham. We were given a leaflet based on Wikipedia to explain the English idiomatic phrase: "Mad as a March hare". This idiomatic phrase is 'based on popular belief about hares' behaviour at the beginning of the long breeding season, which lasts from February to September in Britain. Early in the season, unreceptive females often use their forelegs to repel overenthusiastic males. It used to be incorrectly believed that these bouts were between males fighting for breeding supremacy' (Wikipedia, 2015). This behavior resembles a kind of 'mad' state. The 'March Hare' is one of the iconic characters in Lewis Carroll's 'Alice's Adventures in Wonderland'. In the UK March is also the month of the 'tax calendar year', which usually tends to be a period of stress.

planning the financial year can have a positive effect on the whole ability for a practice to maximise the chances of getting an optimum achievement in QOF points.

In the first meeting, the QOF team discussed the main changes in QOF rules: what indicators have being added or what indicators have been retired. In this meeting the staff were very happy with their QOF overall achievement (98%) and, more importantly, that government has retired several QOF targets such as the biopsychosocial assessment in depression, the GP Physical Activity Questionnaire (GPPAQ), the erectile dysfunction indicators in diabetes, amongst others (BMA, NHS Employers, & NHS England, 2014).

As observed by Checkland et al. (2007, p. 705) targets are addressed by the QOF team as a 'technical problem ('How can we collect this information/send for these patients?') rather than as a clinical one'. In other words, clinical relevance for each individual targets is dealt with as a secondary matter. These practices are adapting to a centrally dictated policy.

The subsequent meetings would involve implementing the quality framework. In this regard, three major points are worth discussing: (1) The strategy to increase some disease prevalence rates; (2) Deploying the practice workforce in accordance with QOF's health care style; (3) The tick box exercise, as QOF induces new artificialities into patients' care.

Prevalence: trying to encapsulate more patients or conditions

As previously mentioned, at the beginning of new financial year, practices usually will have QOF planning meetings. In these meetings, one of the strategies will be to search for areas where they can increase their disease prevalence rates and generate more income for the medical group:

> ***MF5:*** *We also have to look at prevalence, because we should be increasing the prevalence* [specific disease registers], *so we have a report…hmm…'report analysis programme'* [software] *and this give us things. If patients* [have been] *seen in the hospital they might have them down as COPD…we might not, so we can put information of like that, looking at the patients records, seeing if they are COPD, so we can look at…hmm…coding anomalies…from the hospital that might raise our prevalence…hmm…*
>
> ***AHN:*** *Just to see if I understood, you kind of monitor broadly to see if any people who have been discharged for any particular condition, that belongs to your practice and if you can register them here, for that particular condition* [coding] *so, your prevalence will increase and this will bring more points for the practice…*

> ***MF5**: Yes, that's just one of the ways, because we also can look at some… we have our planning meetings in April, and we go through with Dr 'GP'…he'll…we'll decide on the areas where prevalence needs to be raised…hmm…so as well as planning for our existing patients that we know have a certain chronic diseases…hmm…we also try to identify…hmm…certain areas where about the prevalence is low…we'll be looking for those as well. So, you know…the 'reporting system' is one way…but we can also do our own practice-based reports and we can look into certain patients and certain medications that don't have the chronic disease codes…hmm…because quite often we do have coding issues…where a GP might have added a medication and not put the actual* [code]…

This strategy is part of the 'QOF game' that organises the managerial staff to think in ways of maximising the practice incomes. Despite the fact that QOF is based on a standardised disease concept - for instance, that all diabetic patients are the same or behave the same – general practitioners know that diseases are heterogeneous phenomena (Welch & Black, 2010). This generates a spectrum to play with: selective processes whereby the "easy" patients will be valued and the "hard" ones will be excluded at the end of financial year. In other words, practices play the QOF game by stretching the disease band to maximise potential earnings, which later on, during the financial year, can be adjusted by excluding those 'hard to reach patients'. These are the patients that GP practices find it difficult to reach in terms of QOF parameters or who are non-compliant, i.e. do not usually attend practice clinics or adhere to clinical recommendations.

> *'I…I'll probably make two…two further points…hmm…one of them…just that… you've got on record something we've discussed about prevalence of disease…hmm, and…I have seen occasional examples of prevalence of disease apparently…hmm…going up quite remarkably…hmm…and that may be an…an element of, as you say, gaming…hmm…but…I have not seen that happening on any great scale and very isolated incidents…hmm…the exception reporting was another element you mentioned about gaming…hmm…that's a bit more common for practices to do that and sometimes it's for very good reasons, because people work in very difficult circumstances at times…and if you're in a leafy suburb or you've got a sort of practice full of drug addicts, it's going to be a very different reality'.* [GP6]

As stated above, GP practices in more deprived areas face greater difficulties in putting patients under the same QOF criteria, when compared to those practices operating in 'leafy

suburbs'. Therefore, QOF exception reporting might be putting at risk its aim at reducing health care inequalities across the country. In fact, the initial downward trend in health inequality in the UK was almost nullified, and currently no evidence supports an overall reduction in health inequalities with the introduction of QOF (Dixon et al., 2011).

Another issue related to prevalence refers to the possibility of this increase happening to an already 'diseased' patient that raises practice earnings but not necessarily the workload. For instance, as patients grow older the chances of having other associated disease conditions increase, such as high cholesterol, chronic kidney disease, hypertension, and so on. In this regard, QOF rules allow for a multiplying factor, which is financially appealing. For example, if a patient has more than one synergic disease such as CVD, stroke, and diabetes, according to QOF, these diseases all require control of cholesterol levels. For the practice, this context represents receiving QOF points for each of the diseases or conditions, despite the action and care being done to the same patient. Thus, by achieving the cholesterol level in one patient the practice gets QOF points for all associated disease indicators. The IT system does not recognise that the action was done on the same person (i.e. it does not integrate the care information). The reverse is equally true: when practice teams exclude the need for a QOF-task for a particular condition, they correspondingly dismiss the same requirement for other conditions attached to the same patient. This can be exemplified through the dialogue about the flu vaccination given to one patient with three QOF indicators:

> ***MF2:*** *He features on the…he also got diabetes…so he features there, DM010 and COPD006* [QOF coding Diabetes Mellitus and Chronic Obstructive Pulmonary Disease]...
>
> ***AHN:*** *OK, just one question about this…what you're showing to me: so, the same…hmm…action, that is, the vaccination…is double positioned because he's diabetic and also COPD…*
>
> ***MF2:*** *Yeah, yeah, yeah…and he also…had a stroke…*
>
> ***AHN:*** *So, in his case it's three times the same patient. If he had…agreed…he had agreed in receiving the vaccination…*
>
> ***MF2:*** *It would have cleared…all three…*
>
> ***AHN:*** *…all three…but would you get paid by the three?*

MF2: *No, we only…well…we receive QOF points for the three…*

This is the 'QOF game' multiplying points by focusing on disease management rather than patient care, reinforcing a fragmentary disease oriented model instead of a patient integrated care model. Thus, QOF can induce a 'cumulative gaming' process where targets can be added on the same patient without much increase in the workload. In this context, 'multiple-comorbid' elderly patients become 'value for money' for GP practices: first, they are likely to fit within all disease criteria; second, they tend to be medicalised for all those disease conditions they tolerate; finally they may be excepted - as the practice approaches March 31st - for 'the bits' that the practice cannot achieve. All these circumstances are backed by the powerful discourse of evidence-based medicine.

> *'…In a way we're only using the game…in order to do something which has some degree of overall benefit…and, whether people who are borderline hypertensive who would then getting drawn into QOF…need to have treatment and follow up…well, that's debatable, but the evidence says that this is what we should be doing…hmm…so…I think most people would say it's reasonable, even though one might question exactly what's…what's going on…'* [GP6]

The QOF multiplying factor associated with diseases' borderline construct, framed as 'debatable' areas, constitute one of the options that practices can explore to increase their prevalence. Unfortunately, the monetary incentive creates a disequilibrium, which tends to favour labelling more patients as sick.

Hence, the QOF scheme has an embedded logic of the 'more disease the better' in general practice. For example, I was having a conversation with a GP about health staff coding behaviours to avoid QOF chores. Instead of using the QOF Read codes they were deliberately using a surrogate code, particularly in the case of depression indicators. As discussed in Chapter Eight (p. 218) this behaviour was similarly found in other qualitative studies (Mitchell, Dwyer, Hagan, & Mathers, 2011; Lester, Matharu, Mohammed, Lester, & Foskett-Tharby, 2013). However, this conduct works against practice income and data quality, as discussed below:

> ***AHN:*** *Do you think this…the fact that some doctors are…putting 'depressive mood' instead of…hmm…'depression'…is it to avoid going through the whole…requirements of QOF?*
>
> ***GP11:*** *Yeah, yeah, definitely…definitely…but that's not good for our…data quality…*

AHN: *As well for the…for the income that is attached to this behaviour, right?*

GP11*: Yes, because the more you've got…the more you get…per points…*

AHN: *So, the more patients on depression, the more you get…in terms of income as well…*

GP11: *Yes…yes…*

AHN: *So, there is no point to exclude them by doing…by coding* [them] *as…as depressive mood instead of putting the…the real code…*

GP11: *The real code in, yeah, because the more you have on your register…*[prevalence] *the more you will get, basically…OK…hmmm, if you don't have many, you won't have…hmm…your amount of pay is going to be…less…*

This biomedical technology, which promotes '*the more you have on your register* [prevalence] *the more you will get'* principle, increases the demands in health services. This means that general practices are framing their services as an assembly line model of management care (Harrison, 2002).

Transformation in GP practices' landscape

The transformation in practices' landscape, as they have to comply with this 'quality scheme', has been portrayed as 'playing the QOF game'. To increase the chances of winning the QOF-tournament, practices' deployment of their workforce has become a core strategy to assure that QOF targets are met. As discussed throughout Chapter Four, general practice income depends on patients' compliance with QOF disease management. To improve patients' adherence, a practice has to plan ahead and gauge what it needs in order to succeed in its enterprise:

AHN: *QOF is a point-based system, right, so as a manager what are your strategies to get most of the scheme? How you organise things to get the most of this?*

MF5: *What we have to look at is…this is why we have our planning meetings in April to try and make a plan for the whole…for the rest of the year…hmm…we need to make sure that we've got enough appointments, that's one of the first things…hmm… look at our QOF team, how they recall the patients in…and…most have…regular meetings, we have a meeting every week with the QOF team, we also have a monthly meeting with…hmm…the leads…we assign lead areas to clinicians…a sort of dementia to Dr 'GP', because they* [GP and nurses] *need to take ownership as well. If there's a particular area that isn't…hmm…you know, looking like*

we're not going to hit, we would call a meeting. So we may have a diabetes meeting or a COPD meeting, so those are the sort of things we look and do throughout the year.

Apart from assigning lead areas to GPs or nurses, one common tactic is to set a chronic disease management strategy, known as the '''three Rs'': registration, recall and regular review' (Swinglehurst et al., 2012, p. 1). For instance, Practice 'B' sends letters of invitation for clinical reviews to registered patients on their birthday month to keep on track with chronic disease management such as diabetes, COPD/asthma, mental health, and so on. This call and recall system comprises a chasing strategy to maximise patients' adherence to QOF policies (Checkland et al., 2007), but equally guarantees that if the patients do not attend the clinical reviews after three invitation letters, GP practices can 'exclude' them at the end of each financial year for that particular QOF indicator. In this new landscape, general practice relies on nurse teams to do most of the QOF templates, complemented by some GPs' input. This can be considered as the current general practice default for QOF's activities and workload division (McGregor et al., 2008).

However, practice organisation does not necessarily reflect quality in health care. The QOF seems to represent a style of doing things. In other words, it might represent a performance in playing the 'QOF game', as stated by a GP:

GP8: *the G'PAQ…yeah…which is go*[ing]*…which is going out of QOF* [meaning that the GPPAQ will be retired the next financial year]*…but there's always…there's always other things in QOF I think which are just ridiculous…they don't really have a place in…improving quality of care for patients and they're ticking boxes…I do think that QOF…is a bit of game...*

AHN: *A game…?*

GP8: *Hmm-mm ((nodding))…although it's useful…*[for organising the management of chronic diseases]*...I think it's a game and it's how you play the game…*

The GP then continued to talk about QOF by comparing with a previous practice work experience. In this regard, QOF was seen as game, being difficult to compare practices' quality based on QOF results. Despite acknowledging some improvements in chronic disease management with the introduction of QOF, this GP thinks that QOF just translates how good or bad a practice is in playing with QOF's rules, but not the care itself:

> *'…Well, actually they've got* [GP's previous practice] *fewer nursing staff than here, but they are only split in two sites and have a comparable number of doctors and…without much difficulty…they hit QOF targets…quite consistently, quite easily year after year…I don't think they're as good practice as here…but they can hit the QOF…and they just play the game better…they manage the game better, they manage the nurses better…they manage the game better, they manage the nurses better…they manage…'* [GP8]

As we progressed in our conversation, the GP gave a nice example of how things are moving or being shaped by the QOF managerial structure, distancing general practice from a more personalised type of environment:

> *'I think they are going to start doing at these practices…they have an automated blood pressure machine, so, the patient comes in just put the arm, they get told they need their blood pressure check, like someone in a repeat prescription, they have those little stickers they put on saying: "You need a blood pressure check* [and] *you're not getting more medication until you've done it"…so, rather than coming for a health care assistant and taking off her…10-minute appointments or 20-minute appointments…they come in to…the surgery and there's* [a] *little room that they get directed to…stick their arm into this machine, take their blood pressure, it has a print out and take it out to the desk, they hand it in…and the person behind the desk has the triggers, so, if it's…below certain level…that's fine…hmm…they get given the GPPAQ* [GP Physical Activity Questionnaire] *form…so, they get given any information in the leaflet about regular exercise, just tick the box of lifestyle advice, just from given that leaflet and they haven't seen a doctor or a health care assistant…or a nurse…so that's the game like…anybody can…be good at it, it's just how you play it'.* [GP8]

The above statement reflects the way that QOF is shaping general practice by focusing on data gathering processes rather than a personalised relationship between health staff and patients. According to Checkland et al. (2007, p. 693) with the introduction of QOF there has been a vital shift in general practice:

> Electronic data collection had increased in importance…with consequences both for clinician-patient interactions and for the structures and processes in the practices, as uniform data collection instruments are put in place that privilege "hard" biomedical data that can be easily coded above "softer", more patient-centred information.

The need for a 'uniform data collection' generates a more bureaucratic and mechanistic style of health care services within which patients tend to be anonymised or numbered by an industrial style of care: the tick box exercise.

QOF templates: a tick box exercise

The idea of templates as a quality frame to assure that all steps in the care plan will be covered has a fragile basis. Health staff can have different approaches to the same template. The QOF scheme hardly measures these variances in the care delivered. For instance, in a nurse-led chronic disease practice service the attitudes to templates tend to be different from a GP-led service, since nurses have a more guideline based type of consultation (McGregor et al., 2008). Thus, the same template permits a more in-depth type of care or just a superficial tick box attitude.

> ***GP7:*** *Hmm…you know you can say: '- Have you done this? Yes or no'…sometimes is the question of how…how well you've done it…I could have said that…yes, I discussed diet:* [GP] *'-Is your diet OK?* [Patient]: *Yes*. [GP]: *Tick!' Or, I might go in to have a five-minute discussion about diet and what the patient should and shouldn't eat and what the portion should be like…and that's quite…different from…a quality point of view…*
>
> ***AHN:*** *Yeah…but for…the QOF is just…*
>
> ***GP7:*** [for the] *QOF is…is just…*
>
> ***AHN:*** *It's just a tick!*
>
> ***GP7:*** *Yes… 'Is your diet OK?' Tick… 'Have you had any fits? Yes or no…'*

As discussed above, QOF templates create artificiality and a control mechanism, by requiring clinicians to tick every box. The following explanation given by a nurse illustrates the variation in the approach to the same COPD template amongst nurses. She comments about a colleague that is faster in doing the same COPD clinic:

> ***N3:*** *We've had one nurse who came in to do…hmm…I think she worked for the* [medical group]*, but she didn't work with us…she said that she would come and do some spirometry and COPD clinics to help us to catch up…and she was going to see patients in 20 minutes, and that was doing the spirometry and doing the review* [together]. *Well, I don't <u>honestly</u> know how she could get through that?…Because you're dealing with…we're dealing with a*

mixed bag…but the majority of your patients are elderly…and you've got to have your three…short puffs…then you've got to have…and she was#…I don't know, if she was going to do reversibility or just the spirometry…and then you've got at least your three peak-flows…and that takes [time for] *some doing for some elderly patients to…get through that in 10 minutes so…then they can have 10 minutes for a review…so, but she maybe didn't look at…she's maybe just looked the spirometry and looked the medication…and didn't talk about the other* [things]*…family history and all the other things…that are on the template…I'll show you a COPD template…I'll go to that lady's note actually…but it's quite an elaborated…template…hmm…*[opening the COPD template, Figure 6.1]*…I usually…all of this is done by the…because they usually come and see the health carer* [health care assistant]*…she does the height and weight and…lifestyle…and all of that…*

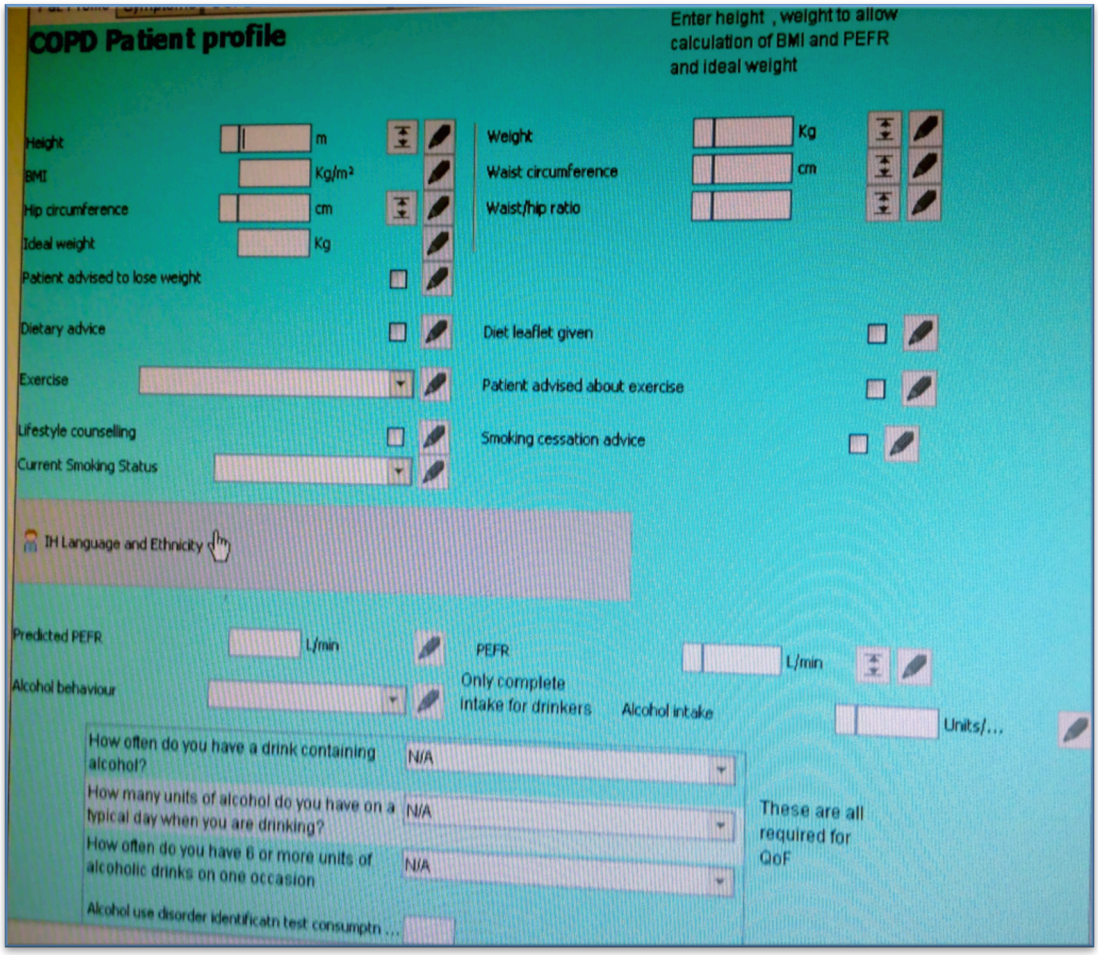


Figure 6.1. Chronic Obstructive Pulmonary Disease template example.

AHN: [Taking pictures] *there is no patient information, just the template…*(Figure 6.1, showing at the bottom right hand side the message: 'these are all required for QOF')

N3: *Yes, there's no patient information…*[silence while taking the picture]…

AHN: *Thank you…*

N3: *…so, she* [the health care assistant] *will do all of that then they will come in to me and we'll go through the symptoms…and then we'll see whether they need a COPD…hmm…emergency packs, whether they've got them…*

The above dialogue shows two things: first, QOF's health care style is becoming one of 'industrial production' similar to an assembly line organised through a series of tick-box templates. Second, the same template allows for different approaches. Thus, what QOF is measuring is the data production and not the nature of the care delivered. That is why some authors have referred to it as a pay-for-reporting system (Kordowicz & Ashworth, 2011, p. 85). This questions the very logic behind the QOF since the performance itself cannot be measured. Thus, the QOF scheme drives practice teams towards data production rather than care by embedding financially linked activities into the general practice care model.

In the spectrum of data production, GPs' approaches to templates differ from those of nurses. For instance, Figure 6.2 shows the evolution of QOF indicators in a 10-minute GP consultation with a patient being treated for psychiatric illness. The requirements of QOF for this type of patient involve various preventive actions. However, the GP just ignored the opportunity of covering alcohol and smoking QOF requirements as well as the chance to offer counselling or other support. It was just a matter of ticking the boxes to rapidly turn QOF timeline nine rows from red to green (seven out of nine red QOF items) as can be seen from A, B, and C picture evolution (Figure 6.2). In terms of QOF, the action performed was just the blood pressure and a blood sample requested for checking cholesterol. The other bits were just a matter of ticking boxes. However, care should not be framed as a cookbook exercise. Patients' diseases need to be looked after in respect to their uniqueness disease experience, i.e. illness (Frank, 2002).

This attitude possibly reflects the fact that the doctor might know the patient from previous follow up and did not want to be intrusive and ask those 'silly' questions about alcohol and smoking. But, compared to the ideal quality standard proposed by QOF, this shows not only its artificiality, but equally how data production is open to manipulation (Dowrick et al., 2009).

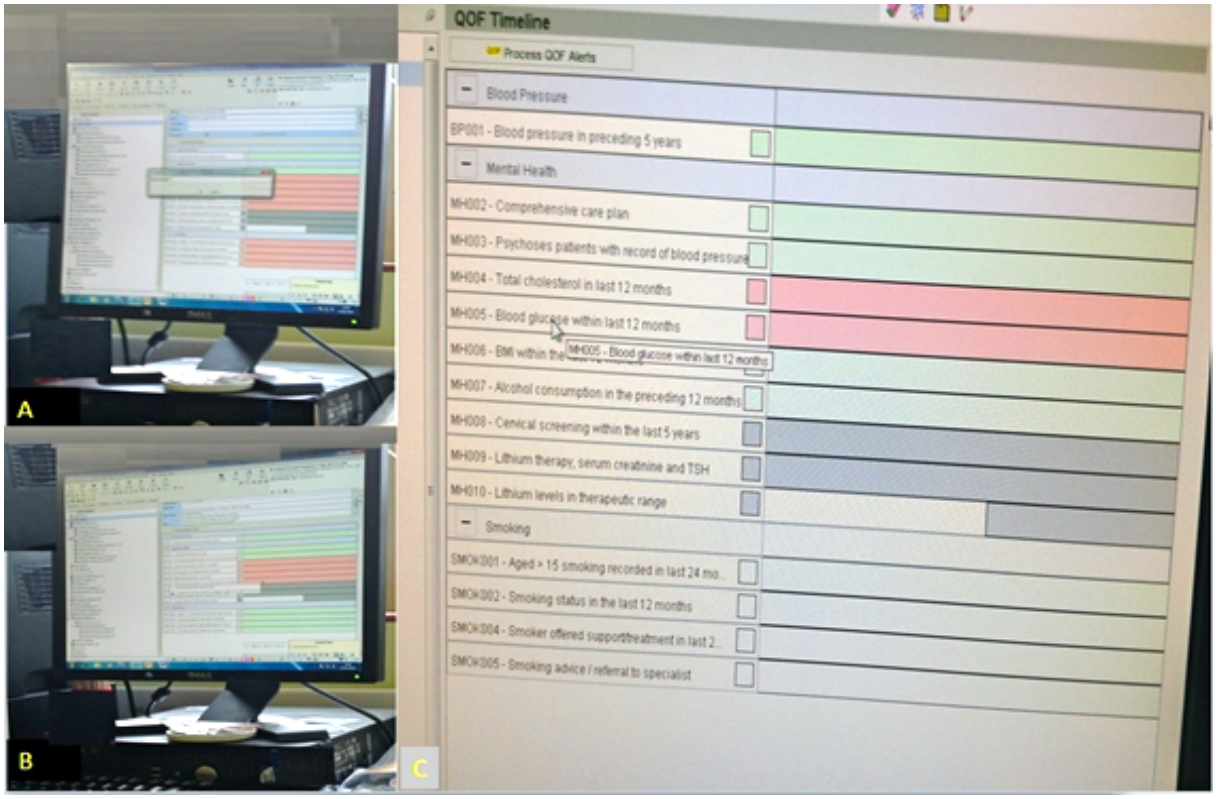


Figure 6.2. QOF timeline showing the progression from red to green.

Behind the QOF exists a notion of improvement in general practice standard of care with the introduction 'evidence-based' targets. In the QOF scheme, care has been narrowed to the disease concept, disregarding the nuances required when caring for somebody. As Arthur Frank (2002, p. 45) argues, 'the categories into which medicine places its patients are relevant to disease, not to illness. They are very useful for treatment, but only get in the way of care'. As general practice deals mostly with patients with chronic conditions, they need more care and support to deal with their illness (McWhinney & Freeman, 2009), and therefore, targets should be placed in the context of patients' needs and life aspirations. As I have observed, QOF cannot really measure nuances in care, despite the use of same templates. What health staff members have to do is to play the 'QOF game':

> ***N2:*** *So, that hitting the targets doesn't necessarily mean…that the patient is well cared for, you know, in my opinion…*
>
> ***AHN:*** *Do you think people have different approach to the same template, for example?*
>
> ***N2:*** *Definitely, yeah…probably the way I approach things is entirely different of somebody else does…*

AHN: *But at the end they…they will create this illusion that is…everything is done, it's equal, it's standardised…*

N2: *Yes, but it's not a standardisation, is it? At the end of the day…and I guess from your point of view observing different people doing it in different ways…you probably see different levels of care…*

AHN: *Of approaches…to the same…to the same template…*

The QOF scheme combines the intrinsic characteristic of audit and management, framing quality as 'certain style of management processes'. This constitutes a meta-regulatory process producing a uniform, predictable and verifiable pseudo-reality (Power, 1997, p. 59). This phenomenon was perceived as a 'game in itself' by some GPs, rephrasing QOF as something 'artificial'. This was expressed more clearly by a nurse in the following dialogue:

N2: *…You know…it's important that we hit our targets and hit QOF, you know, but…you have to…maintain high standards of patient care as well, and I don't think QOF measures the quality…of care…*

AHN: *Yes, why?*

N2*: Because it just measures a framework, it just measures…targets…*

AHN: *OK…*

It seems that QOF masks the natural fluctuation of different patterns in the care service. This might give the impression that QOF is providing a best practice environment. However, QOF might only be building a 'smoky mirror' that prevents the public from seeing the reality on the ground, as clearly expressed by the nurse (N2): QOF *'measures a framework, it just measures targets'*. Thus, QOF has the potential to divert the 'first-order performance objectives' by 'focusing on the management system for defining and monitoring performance' (Power, 2003, p. 189). In other words, QOF divides professionals' attention towards patients' complaints with that of data production, which not necessarily relates to professionals' actual care performance. This creates mixed feelings about this 'quality' scheme. In a 'recoding' activity on QOF disease indicators I shared what I was observing with an experienced GP about QOF's disconnection with day-to-day care, as we went through some code amendments:

AHN: *Sometimes I think QOF doesn't dialogue with the reality…*

GP11: *No, true, yes…*

AHN: *Because the patient was properly cared for, anyway* [reading the patients' note]*…since he started on antidepressant drugs…*

GP11: *Yeah, yeah, yeah…you're totally right…you are totally right…*

AHN: *It becomes just a matter of coding and recoding…rather…and doesn't translate what…is really going on in terms of patient…care…*

GP11: *Yeah, yeah, the actual patient care, the actual patient work…yeah, yeah, true, yeah…that's why a lot of people* [health staff] *resist QOF for that particular reason…it's not the true reflection, some of them <u>are</u> the true reflection of a problem…some of them are <u>not</u>…*

Thus, QOF creates an artificiality, which is in dissymmetry with the reality, making practice teams to divert their attention towards the fulfilment of QOF criteria. As Swinglehurst et al. (2012, p. 8) state:

> This reflects a tension between different ways of framing the patient - the patient as an individual whose illness narrative is unique, and the patient as one of a population, all of whom need standardised management of the 'same' disease.

This means that practices have to adjust themselves to the QOF frame in order to make it work for them and, consequently, win the QOF 'game'. However, as the above GP has stated, 'a lot of people resist QOF', producing a snowball effect as practices approach the end of financial year.

MAKING QOF WORK: DRIVING OR BEING DRIVEN?

The effort to organise a working environment to meet QOF requirements creates inauthenticity, which health professionals have to adapt to, as expressed by a GP:

> *'…But when you've been a GP for a while…for some time…hmm…I think that's where it becomes more artificial and…I know that trainees have said: "It looks like a number counting game", you know…hmm…you lose that relationship with medicine…'* [GP14]

What the above GP expresses by *'you lose that relationship with medicine'* refers to GPs' activities becoming a 'number counting game'. This last phrase summarises both faces of

QOF: ‘number counting’ and an artificial ‘game’. The former represents the commercial type of medicine where gathering points will generate the practice revenue. The latter refers to the artificiality that drives practices to organise their services in order to conform to QOF requirements, i.e. playing the ‘QOF game’. This scenario conflicts with patients’ needs or personal agendas, resulting in general practice losing its patient-centeredness.

> *‘Now, with the introduction of the quartile system...or...hmm...having to…hmm…have extremely high targets for* [referring to blood pressure <140/90 for patients up to 79 years old]*...for people who would not be appropriate: the very elderly, the terminally ill, the people with comorbidities...hmm...it's stopped being evidence-based and much more a tick box exercise...so…we spend a lot of time trying to decide whether we are going to exclude people and finding ways of making the QOF work rather than doing good medicine’.* [GP2]

The above quotation expresses GP’s frustration at being diverted from practicing good medicine, ironically being prevented from practicing EBM and at having their time consumed in ‘making the QOF work’. In fact, the QOF as biomedical technology is driving health staff’s work by making them work in accordance to its rules. The QOF scheme has become so domineering that it has got a life in its own:

> *‘It's turned into a monster where…instead of serving the patients it's serving itself. Or, it's serving the politicians to either give us less money, or to…to get us to dance their tune based on non-medical people’s priorities’.* [GP1]

According to this last quotation, it seems that QOF represents more a style of doing things rather than a ‘quality’ evidence-driven policy. Thus, GP surgeries are being transformed by QOF rules as services are organised in a way that maximises data collection and simultaneously delivers chronic disease care management. Therefore, data collection has become a central activity for general practice care quality standards.

However, one GP to whom I spoke had a different understanding. I was exploring with him, as we were looking into patients’ notes, about the possibility of publicising the QOF results in order to allow patients to compare quality across practices, and to some extent, empower them. For this GP, QOF might convey wrong information, representing just how well a practice group plays the ‘QOF game’:

> *‘…You know, for patients to look at and they might get the wrong impression about…what… what practices are doing better than ours…but it depends on how…what practices are*

playing the game better than other practices are playing the game at…you know…so…it's not… it's not that easy to look at'. [GP11]

In another conversation with a GP, he spontaneously portrayed to which extent he agreed with playing some of the QOF game:

'…hmm…some of the other stuff…as physical activity and hypertension, yeah…I'll do it because it's easy…you know, I'll play the game for that one because…yeah…I suppose I do tell people to get some more exercise and get bit fit and other stuff…hmm…probably this lady needs to be more active and stuff like that…hmm'… [GP13]

As indicated, QOF is playing a different 'tune' and practices have to learn how to 'dance' in accordance to its 'rhythm' to get the most from this points-based system. However, from December onwards the 'music pace' changes, causing stress for all practice team staff.

As discussed in Chapter Four, health professionals' consultation style is more affected by the demands of QOF from December onwards. QOF seasonality represents 'an anomaly' or a 'noise' produced by its dissymmetry with reality. In spite of the planning process and organising the practices to 'dance' in accordance to QOF requirements, reality challenges its *modus operandi*. Thus, QOF tasks tend to accumulate as practices reach the end of financial year, as explained by a member of managerial staff.

'I think you really need to keep things on a month-to-month basis…hmm…but no matter how much you try to do that it always has…it always seems to build up at back end of the year…what we keep…I mean, I think…hmm…having systems in place to recall the patients it's definitely better, because she may…she would be coming in and you've got set tests, so that's got to be better for the patients…hmm…I think it does have an effect on…the routine appointments, I don't know what you can [do about it]*…because even trying to keep it on a month* [basis]*…hmm…we try and plan each month, this is what has to be done, so you don't get the big push at the end…hmm…we've never managed to quite do that…'* [MF5]

As expressed above, QOF tasks inevitably accumulate as practices reach the end of the financial year and this has been a constant phenomenon in previous years, as '*we've never managed to quite do that'*. This seasonality reveals QOF's artificiality, bringing with it several interconnected problems, since in a short period of time the practice has to produce an enormous quantity of consultations, clinical reviews, and laboratory tests in order to achieve QOF targets.

For instance, Chapter Five (p. 127) exemplified the big gap in QOF points from November until the end of financial year that practice 'A' had to solve. This need to bring many patients for reviews affects non-target patients who might face difficulties accessing the GP or nurse. Additionally, the pressure upon professionals to do 'QOF stuff' challenges their autonomy, but also creates opportunities for salaried staff to have their 'share of the pie'.

Patients' access to health services

The QOF scheme depends on patient compliance to clinical reviews and follow-ups. However, as not all patients adhere to QOF's recommendations (Figure 6.3), QOF-tasks and reviews accumulate at the end of the financial year.

Figure 6.3. Information to patients about the number of patients who did not attend. On the top of this figure, the information is shown on the practice's website. On the bottom, the information is displayed in the practice's waiting room.

Figure 6.3 shows that in both surgeries patients are made aware of non-attending behaviour either in the waiting room or in the practice's webpage. In fact, usually patients are 'blamed' for not attending the consultations, labelled as DNA patients (those who Did Not Attend).

This absenteeism might reflect patients' initial agreement with the invitation for a chronic disease review, but eventually they do not turn up for their appointments. Consequently, from December onwards the number of patients booked for the purpose of doing QOF tasks may clash with those patients really wanting to see health staff.

> ***MF4:*** *There's something as well that you lot, and I'll say that to be provocative, want to do to me that I don't want you to do, but you* [the doctors] *keep trying to do to me, you overtreat me, you over examine me, you prod me in ways I didn't want you to prod me…*
>
> ***AHN:*** *Give me an example of this…*
>
> ***MF4****: Well, for example, one of the…one of what you've mentioned* [about] *QOF, right…I didn't ask you* [the doctor] *to do QOF on me* [as a patient]. *I've never gone to a doctor and said: "Give me QOF!" Yeah, I didn't ask to be brought in to have my, you know, my stomach prodded and felt, and so on and so forth…*
>
> ***AHN****: Your urine taken…*
>
> ***MF4****: …my 'wee' taken, you know, taken my blood pressure…and asking me to undress, you know…prodding me, I didn't ask for it! -"Thank you very much!" But you keep telling me that –"It's good for you"…and therefore because you've decided, as my doctor, that is good for me, I have to suffer this. But when I <u>want</u> to see you, when <u>I'm worried</u> of something, I can't get in to see you.*

As mentioned above, QOF seems to be driven by public health agenda, which can sometimes clash with patients' understanding of what is more important for them in a given time. Nevertheless, as observed by a GP, this might be detrimental to patients' access to proper care, diverting health staff to concentrate on the 'periphery' rather than on patients' complaints or their real health status.

> *'It has caused concern because…meeting your QOF points or targets <u>should</u>…fall out of your normal day-to-day care…it shouldn't be added on…or bolted on…to ask lots of questions and the concern there is that…we may <u>miss</u> the major problem that the patient has come for, because we're so busy asking about whether they smoke, what their weight is, whether they want this tablet or that tablet…so…that we lose the point of the consultation and…we <u>miss</u> the fact that they are <u>significantly</u> depressed and they're losing weight because they've got cancer…so, we call it the "elephant in the room"…you <u>miss</u> the "elephant in the <u>room</u>" because you are focusing on the peripheries.'* [GP12]

As the GP continues to explain, this situation is particularly true as practices move towards the end of financial year:

> *'…And we get a "mad panic"…from about February to April…because we haven't documented things appropriately in previous parts of the year…to make sure the recording is appropriate, because QOF has to be recorded…as…the "Read codes", the coding system, otherwise it is not acceptable'.* [GP12]

This 'mad panic', or more traditionally the 'Mad March Hare', is a reflex of QOF seasonality. Pressurised by a target-driven care approach, health professionals can end up not just missing, but in fact ignoring patients' agendas and needs. This pressure is felt at all levels of practices, from managers to nurses and GPs. However, this is not just affecting consultation encounters; similarly, it is causing barriers to patients to access a professional health staff:

> ***AHN:*** *You said* [in the meeting]: *"to burn the…the slots with* [QOF] *people…and* [those] *people who would want to come and see you…would be booked by* [QOF stuff]"…
>
> ***GP13:*** *Yeah…I had…last Friday I had my first patient was booked in to do just some QOF mental health stuff…didn't come…so, she didn't want to come…I didn't want to be there…and someone who did want to be here couldn't be seen…and then I had three other people booked in who failed to attend…and I was teaching one of the F2 registrars…so, in the end I had…five patients that I think I saw that morning and…I don't think I was very productive ((slightly laughing))…*
>
> ***AHN:*** *No, definitely not…*

The GP then continues to explain that situation would be more likely to occur for the coming weeks, as they were approaching the end of March:

> ***GP13:*** *…hmm…and this week we haven't got any appointments…we have no appointments until next week…so…*
>
> ***AHN:*** *Which are filled in with…with 'QOF stuff' to do…*
>
> ***GP13:*** *Probably…so, that kid* [referring to a child we saw together] *who has been going on to the walk-in centre…with multiple infections…can't get in to see us…so, I ended up spending twice as long trying to stop her go to the walk-in centre and actually* [to] *come here…but we*

can't see them…so, we…we've got something wrong…but truly, I'm not in control of…(hh)…the workload…so…((voice fading out)).

The fact that some patients do not attend might represent a side effect of practices' chasing strategy to bring patients into the surgery to do QOF-tasks. At the same time, it is competing with non-target patients' access to see a GP. The same situation occurs with nurses, since they have a very active role in running the chronic disease clinics:

N4: *At this time of the year…from now…until the end of March…all the appointments…we have no nurse appointments, because they are all taken up by the patients… for QOF!*

AHN*: OK… that you've booked…or pre-booked…for QOF…so patients who want to come and see you… it's becoming more difficult…basically…*

N4: *Yeah…*

The above dialogue with a nurse confirmed that as practices reach the end of QOF financial year it becomes more difficult for patients to see the health staff. Although the managerial team tries to balance QOF requirements and patients' demands to see a member of health care, QOF tends to predominate as practices approach this period of the year, as explained below:

'…Yes, I think it can and I think, definitely, at certain times of the year. At the minute, if you are behind in any of your reviews you're going to be really trying to get these patients in, hmm…which will be taken up…hmm…sort of for acute patients or patients without chronic diseases [non-QOF target patients]. *So, we will be using more appointments…hmm…to try and get our QOF patients in to hit the targets…hmm…because coming up to the end of March, there's a bigger push because…you know…you've got to get a certain amount of people…hmm…in about a four-week period…where in April, you know…you've got the rest of the year to get them in…hmm…but now, because you're pushing…you probably are going to be…having a bit of an effect…on a patient's access to routine patients'.* [MF5]

Thus, for GPs, nurses and managers the QOF scheme might generate unnecessary demands, skewing resources to 'preventive' measures that rely on doubtful evidence, or are based on a high-risk strategy, as discussed in Chapter Five (p. 131). Additionally, QOF might be detrimental to patients' access to health professionals, especially during the wintertime.

QOF and health staff: challenges and opportunities

The increased demands for health provision from December onwards set a mammoth task for practice teams to absorb. This period produces challenges and opportunities to health staff. The challenges concern professionals' autonomy and the opportunities refer to additional money that salaried staff can get.

QOF as a challenge to health professionals' autonomy

The QOF's surveillance mechanism tries to control individual and community by chasing, nagging and persuading patients in for clinical reviews. However, it equally interferes with professionals' autonomy. The QOF scheme is part of a clinical governance strategy to secure that doctors comply with centrally dictated policies (Harrison, 2002). As described in Chapter Four, professional staff members know that they are being monitored. Thus, professionals' autonomy has been reduced to a certain extent, because of the dilemma posed by QOF: if health staff disagree with certain QOF criteria or indicators, to circumvent this problem becomes quite difficult, since the practice will lose money otherwise or will have its quality standards underrated. When someone is 'put against the wall' in this way, it definitely produces distortions and behavioural changes:

> *'We are all very, very negative about it; because we think it's a tool of* [the] *government to...to change our behaviour...It's a GP behaviour modifier...whether, everything for decreasing...hmm…income generation…that's behaviour modification they want…to…hmm…following their personal hobbyhorses or priorities that are based* [on] *non-evidence-based medicine at all…it's one of the public medicine stuff that's going around'.* [GP1]

The above GP clearly identifies QOF's monetary link as a '*behavioural modifier'* technology, which undoubtedly constrains GPs' autonomy. As Foucault (1993, p. 204) argues, the art of governing implies that the 'techniques of the self are integrated into structures of coercion or domination. The contact point, where the individuals are driven by others is tied to the way they conduct themselves'. The QOF scheme has this characteristic of a 'disciplinary space' that induces changes in health professionals' behaviour and practices that are internalised, and self-examined so as to give meaning to their day-to-day practice. For instance, GPs' autonomy is constantly challenged since some of the targets are not 'evidence-based

medicine at all'. Despite dubious evidence of their usefulness for general practice, health staff have to conform to QOF's requirements.

In my personal experience as a GP, medical evidence is not absolute, leaving room for debate and for alternative approaches to the same situation. However, this ethnography shows that the QOF scheme has narrowed doctors' autonomy, forcing them to conform to its rules:

> ***AHN:*** *As I'm saying that…even if you don't…really…hmm…appreciate the way they are treating depression on the…quality scheme…you have…you have to…end up doing it,* [don't you]?
>
> ***GP12:*** *Exactly, there are certain…tick boxes that you <u>have to do</u>…hurdles to jump over, hoops to jump through, whichever…synonyms one looks at or a metaphor…that…we may do…and once we're doing it, you're thinking: "I'm not doing this for the patient, I'm doing it to meet the targets"…and <u>that is a concern</u>…*

The above GP's self-scrutiny shows how QOF is a powerful technology in inducing behavioural changes in general practice. The QOF scheme poses a conundrum to professionals as it mixes 'quality' and 'payment' summarised in the above GP last phrase: *'I'm not doing it for the patient, I'm doing it to meet the targets and that is a concern'*. Why is it a concern? It is so because ethically, 'target', in fact, means 'money' for either the partners or the company. This is an inherent part of commercialised medicine, which tends to put economic needs first. As Pellegrino (1999, pp. 251-252) emphasises:

> The most immediate and urgent ethical consequences of commodification occur at the bedside at the moment of actual decision-making. Here the major issues are divided loyalty, conflicts of interest, conflicts with the traditional ethic of medicine, and challenges to the personal integrity of physicians and nurses.

Since the adoption of the QOF scheme, nurses' workload has increased (McGregor et al., 2008). I spent some time with them both when seeing patients and when doing 'QOF stuff'. The following dialogue with one of the nurses explains how QOF seasonality affects their working environment:

> *'We say every year we're not going to,* [but] *this happens every year…as soon as Christmas is over, it's like: - "twch, twch, twch…- <u>The QOF is coming!</u> The QOF is"… or "-How many points are we at? How many?" You know…and you're forever looking at…you go into*

this…you know…hang on a minute [she then turns to the computer screen to show me the QOF summary spreadsheet]*'* . [N4]

The pressure the practice team faces every December with its need to hit the QOF targets is almost palpable. The utterance above reflects the particular atmosphere that practice staff members were experiencing. It tended to drain their minds and souls, diverting practice team to thinking in terms of points achieved: *'How many points are we at? How many? You know…and you're forever looking at'* - said the nurse. She then continues showing me some QOF targets needing her attention:

[Searching on the computer screen to show me the QOF main targets] *'…we look at the audits…'reporting'…to straight away we're going there…we're going to the QOF: Oh my God!...hmm…"end of year"…see now, there's…osteoporosis, we haven't hit it…we need one* [patient]…, *I know…*[…]*…((laughing))…diabetes…we still only got three greens [out of 13], so we haven't hit it…we need 130 patients for blood pressure, 286….Oh, we only need four microalbumin! Oh, we've done well on that, then…(.hhh)…you know, that's a protein we need 211 urine tests…to get the money or otherwise we don't get it!* […]*…and this time of the year it's an absolutely nightmare for us, because…(.hh)…this time of the year it's almost like: "-We haven't hit the QOF, we haven't hit the QOF, we haven't done this, we haven't done* [that]*"…and we've just drawn out of staff to actually…hmm…*[do it]*…'* [N4]

The above utterance stresses the need for chasing patients for clinical review and for extracting their by-products: -*'You know, that's a protein we need 211 urine tests…to get the money or otherwise we don't get it!'* Then, these by-products are transformed into 'QOF-bites', stored as backup information to be exchanged at the end of each financial year in order to generate practice's revenue. This context creates a 'nightmare climate' as the pressure increases to accommodate the remaining patients and QOF requirements within a short time period.

Most professionals see the value of QOF in helping them to not miss important parts of patients' care, but not its monetary incentive that distorts the patient-practitioner relationship, as highlighted below:

N4: *...So…I totally agree with that* [QOF] *as a prompt…to you to say to the patient: "Do you smoke?" You know…*

AHN: *Do you want any advice on smoking…?*

> ***N4:*** *"Have you thought about giving up smoking?" You know…so, yes, some of the things I do agree with…some of them I disagree, because…they <u>set</u> the targets…they're far too high…they've given you* [the targets] *to say to you: "-We're giving you this money if you do this". And <u>really</u>, some people are just…they're just doing this as a tick box…and not actually looking at the patient as a whole…hmm…which I think is one of the disadvantages…*

The above dialogue shows two things: first, the perception that government is playing with cut-off points by setting the targets 'too high' (the high-risk strategy theme explored in Chapter Five, p. 131). Second, it reiterates the conditional clause embedded in the QOF scheme: -*'We're giving you this money if you do this'*. Clearly, this reduces professionals' autonomy. As a quality scheme, QOF monetary incentives start to distort the relationship, 'shifting the way' health professionals 'look at' the whole patient, as the nurse continued to explain:

> *'…This shifts you…the way you look at your patient…hmm…and that shouldn't be happening…I mean, we've said into a meeting once, we were in it and the doctors were in there, we've said: - "Hmm, yes, the QOF is good for prompting you, but we should be looking at the patient as a whole person rather than just that: we need your smoke, we need your drinking, we need your..."Do you know what I mean? Instead of looking this…at individual things…we should be looking at the patient and saying: "- Right, yes, yes…I know the QOF target is this, but…we want to look at the patient…as he is, and as he comes in…and dealing with that…not with like…what we get paid for"'.* [N4]

My impression is that for nurses, QOF offers mainly the 'stick part' of this managerial structure. This 'quality' framework based on '*We're giving you this money if you do this'* reduces health staff discretionary space, enforcing a tunnel vision with a focus on targets rather than patients' needs (Heath, Hippisley-Cox, & Smeeth, 2007). According to Maisey et al. (2008, p. 137) QOF diverts practices' focus on a 'process-driven medicine' making it difficult to maintain 'a patient-centred approach'. Hence, holism, one of the pillars of general practice, almost vanishes as practices reach the end of financial year (Checkland et al., 2008).

In this scenario, patients become a commodity to be chased, medicalised for extracting bodily information through blood, urine, and so on, as uttered by the above nurse: -*"We need your smoke, we need your drinking, we need your…".* As observed by Checkland et al. (2007, p. 707) this process should not be a surprise since for the Department of Health the introduction of QOF was 'underpinned by a belief in the importance of population-based

medicine and a proactive (case-finding and call and recall-based) approach to primary care'. However, this process almost reverses general practice relationship with the patients and instead of being just 'proactive' general practice has become 'overactive', consuming enormous amount of resources as well as over-medicalising its patients.

Talking to members of staff, they really do not like QOF. They see the utility of having prompts as a reminder, but QOF's compulsory nature, due to its monetary link, according to them, perverts a caring approach to health care. Thus, I suspect that the accumulation of QOF tasks at the end of financial year is in part a reflection of health staff's unwillingness to 'jump through hoops'. However, as it reaches December onwards, they have to try and do most of it, in accordance to QOF requirements, to produce the practice revenue and its 'quality' standards.

QOF as opportunity for an additional source of income to salaried staff

Originally, pay-for-performance was based on incentivising the workers by rewarding them for performing well in accordance with agreed guideline standards. However, UK medical service contract arrangements reward either independent contractor GPs (i.e. partnership model) or shareholders running several general practices' services, as exemplified below:

> ***MF5: …****so each practice…the money would come and go in their budget and it goes…back towards the running of the practices…*
>
> ***AHN:*** *Yeah, but…hmm…the rewarding is not for those who are doing the work…*
>
> ***MF5:*** *No, unfortunately…*
>
> ***AHN:*** *Because that was, I think, the original idea…every worker would have an incentive to keep up…*
>
> ***MF5:*** *Hmm…few years ago we did get a bonus, which I think is an excellent idea, because…especially this year for us, because it's been one of the most difficult years that I've known…hmm…and I know the staff* [members] *have to work extra hard…and…a bonus system would be…would be great. I mean, as managers we tend to buy a small gift…hmm…but from the money that QOF brings in…it goes back into the practice.*

This context creates a rewarding system that reinforces an exploitative working-relation where salaried staff members (mainly nurses), in spite of doing most of the QOF-tasks, have no direct monetary gain (Checkland et al., 2007; McGregor et al., 2008). Additionally, nurses

have less autonomy, since they are bound to protocols, and their perceived ability to protect themselves against QOF's intrusiveness is a daily challenge. The following extract exemplifies this point:

> ***N2:*** *I think it depends on…how well trained your clinicians are, or your nurses are in giving that information…as well…and how motivated they are in providing that information…because I think somebody who isn't highly motivated isn't really putting an awful lot of…effort into it…*
>
> ***AHN:*** *And about motivation, for example, the idea of payment for performance…the money…the money doesn't go to the person…*[because] *you are salaried…*
>
> ***N2:*** *No!*
>
> ***AHN:*** *So, you do the job, but…regardless…*
>
> ***N2:*** *You don't see the dangling carrot…the dangling carrot…the dangling carrot is never for us!…it's for somebody else, so, it seems a pointless exercise, in that sense to me, it seems a pointless exercise…(.hh)…I think if you are internally motivated to actually give good care…then you'll give good care…*
>
> ***AHN:*** *But this regardless of the QOF…*
>
> ***N2:*** *Irrespective of QOF…yes…*

Despite no direct monetary gain, in this commercial health enterprise environment nurses try to get their 'shares' out of it as QOF brings opportunities to increase their earnings by performing overtime work. The QOF seasonality means that as practice teams approach the end of financial year, QOF-tasks accumulate, requiring extra people for chasing and doing the QOF chores:

> ***N2:*** *And what happens is: you'll end up like…*[the managerial staff] *will be emailing us around and saying: "Can you do? Can you…? Can you…? Can you…?"*
>
> ***AHN:*** *Can you? Can you…?*
>
> ***N2:*** *You know, and I just…I'll go through my diary and I think: -"it's an opportunity to earn some overtime". I'll do there, I'll do there, I'll do there and I'll say: - "You don't have to put us in for all of these sessions…but I'm prepared to do them all if you need us"…you know…and* [the managerial staff] *says: -"Yeah, I'm putting you in for them all!"((Laughing)).*

The need for overtime work for doing 'QOF stuff' was confirmed by some members of the managerial team, as one of the consequences of QOF. They try to keep QOF-tasks on a monthly basis, but unfortunately QOF predominates, driving many human resources as practices approach the end of financial year.

> *'We've been putting to extra BP* [blood pressure] *clinics on a week, which is about eight hours a week, over about the last six weeks and that's just with health care assistants, and* [Mrs. Nurse] *has done about eight asthma clinics…hmm…we've had full extra sessions for COPDs and these are nurse practitioners, so they are higher rate than the* [practice] *nurses would be…but, we do have an overtime budget as well…and…even with the extra QOF, we still have one pot that comes out, so we're still trying to fit it in that'.* [MF5]

My understanding is that most of the QOF chores are left to the nursing team. However, as £-QOF circulates in general practice, salaried health staff and even administrative staff try to 'grab' their share through overtime work. This is another aspect, or side effect, of monetary incentives in changing health staff behaviour to secure their share in the bioeconomy of general practice. In spite of its constraints on professional's autonomy, the QOF scheme seems to offer monetary advantages to GPs, nurses, and practices. This might help explain why Maisey et al. (2008) and McDonald et al. (2007) found that QOF has not damaged health staff's internal motivation.

CONCLUSION

This chapter has highlighted how QOF's formalism produces a routinised approach to deal with its bureaucratic nature by playing the 'QOF game'. Instead of analysing QOF's indicators by their clinical plausibility, non-evidence targets are treated as a technical issue: How to reach QOF targets? The QOF scheme logic (the more disease/condition the more money generated) stimulates practice teams to improve their disease prevalence profile and to set up their staff members to chase patients and bring them into GP surgeries to be reviewed, probed, and checked.

Despite the effort to make QOF work on a monthly basis, reality defies its blueprint, producing the 'Mad March Hare' phenomenon at the end of financial year. This context generates some distortions in general practice, prompting practice teams to chase patients in order to secure both personal/practice's incomes and 'quality' standards. Consequently, QOF

fosters a reductionist, mechanistic approach to health care over a more traditional patient-centred approach. This is materialised by a proliferation of template-driven clinics, fragmented by pathologies or conditions, to extract QOF token-information. Thus, QOF arrangements have the potential to conflict with patients' needs and access to general practice.

In the above scenario, QOF has gained a life of its own, producing a meta-reality. This has been portrayed as a 'game' that requires a sort of expertise to play by its rules to generate the data needed for practices. These induced game strategies have implications for the public health quality improvement ideal of general practice, because QOF measures a frame and/or targets, not necessarily the care itself. In other words, QOF might not translate or reflect how the care is actually performed, but just how well a practice plays the QOF game. In this QOF-tournament, the gamesmanship behaviour and its consequences will be discussed further in Chapter Seven.

Chapter Seven

STRETCHING THE QOF's RULES: GAMESMANSHIP BEHAVIOUR

The pay-for-performance in Britain functions within a quasi-market welfare state that adopts a particular view of human motivation and behaviour, as Le Grand (1997, p. 149) states:

> People who finance, operate and use the welfare state are no longer assumed to be either public spirited altruists (knights) or passive recipients of state largesse (pawns); instead they are all considered to be in one way or another self-interested (knaves).

Le Grand points out that fostering self-interested policies might have two main consequences: first, the conversion of 'knights into knaves', which in general society is not seen as morally right; second, it might be detrimental to 'the public good. So, for instance, a system of performance related pay requires reliable and accurate procedures for measuring and monitoring performance; one that cannot be fiddled to indicate better performance than is actually happening' (Le Grand, 1997, p. 163). This, for him, is harder to construct.

As discussed in Chapter Six, QOF's quality ideal has induced 'game' strategies so as 'to indicate a better performance'. In this Chapter I explore gamesmanship as the other end of the spectrum of practice teams' behavioural changes after the introduction of the QOF scheme. The first part of the chapter defines gamesmanship and examines its scope through different ways of applying QOF's rules to maximise practice profits and minimise its losses. The second part illustrates the practice of gamesmanship comprising of several behavioural strategies such as the use of phone calls and phone consultations, software 'shortcuts' (free-text and auto-consultation), exception reporting and code amendments. Thus, from a monetary protocol-driven approach to care observed in Chapter Six, such mechanistic activities sometimes lead towards a more dysfunctional type of behaviour: gamesmanship.

GAMESMANSHIP: DEFINITION AND SCOPE

Gamesmanship is a direct result of self-interest driving forces that the pay-for-performance induces in practice teams either through its 'stick' or by rewarding components. In other words, it represents pay-for-performance side effects of linking improvement in quality care through doctors' or practices' monetary incentives. As a result, data collection (specifically,

electronic data collection) has become an increasingly important fact of life in general practice (Checkland et al., 2007, p. 694). Nevertheless, gamesmanship has a direct consequence and impact on data quality production.

Although this behaviour is usually referred to as 'gaming' in the literature (Doran et al., 2008), gamesmanship is a more accurate term. It encompasses different ways within which practices 'play' QOF's rules to their economic advantage. The Merriam-Webster on-line dictionary gives the following definition of gamesmanship:

> The practice of winning a game or contest by doing things that seem unfair, but that are not actually against the rules or the clever use of skills or tricks to succeed or do something or the art or practice of winning games by questionable expedients without actually violating the rules or the use of ethically dubious methods to gain an objective. (Merriam-Webster on-line dictionary)

Gamesmanship can be understood by its borderline nature: to stretch the rule to its limits in order to succeed in winning the game. At the heart of gamesmanship sits the ambiguity (or the debatable nature) concerning the fairness about the activities performed while playing the 'QOF game'.

During my fieldwork I came across different contexts in which the idea of gamesmanship was expressed or observed. However, being a non-English speaker, the term 'gamesmanship' was not part of my own vocabulary. It really came from the ground, first introduced to me by a GP. I was already in the middle of the fieldwork timeframe, exploring the possibility of what so far I understood as 'gaming', when a GP said:

> *'…And I say that because…we have not achieved targets…on QOF…but then we hear* [of] *other places that have achieved targets, we can't honestly work out how they do it…and I've made a suggestion in the past that the QOF targets of…those practices that are…high achievers…should be invited to tell us how they do it, so we can learn from them…and it's never happened and it made me suspicious…that may be a reason why they achieved it that isn't illegal, but they're…gamesmanship…and they're playing…within the* [QOF] *rules…'* [GP12]

Instead of using the word 'gaming', which in the literature tends to focus on the GP playing with 'exception reporting' for the practice's economic advantage (Gravelle et al., 2008), I decided to use the term gamesmanship for two reasons. First, other researchers have documented 'gaming' behaviour beyond 'exception reporting'. For instance, Dowrick et al.

(2009, p. 5) concluded that 'the potential for gaming or manipulation of pay-for-performance indicators extends beyond explicit exception reporting'. Second, gamesmanship is more precise as it describes a behaviour *'that isn't illegal, but…they're playing with the [QOF] rules'*. In other words, it encompasses all interconnected potential behaviour that implies 'data manipulation of indicators for economic reasons' either for doctors' or practices' advantage (Dowrick et al., 2009, p. 1).

The ambiguity implicit in the term's definition, that casts doubt over a practice's 'behaviour fairness,' better characterises the nature of gamesmanship. For example, its facets were openly discussed in various ways, as quoted below:

> *'And they are also difficult to engage* [referring to patients from deprived areas]*, because a lot of patients that you're trying to get, for example, the epileptics and those ones with mental health, they are notoriously poorer at attending doctors' practices for reviews of any sort, and trying to actually get them…to be reviewed without cheating and bending the rules and doing over phones, which I've done for years…I'll be honest, you know, with certain patient groups you cannot engage them…and…and it's almost…whoever has designed these QOF indicators and areas to look at knows that...it's not achievable'.* [GP4]

In the focus group, the theme of what would be defined as gamesmanship was starting to be delineated as it was impossible to make the QOF work *'without cheating, bending the rules and doing over phones'*. Another aspect was to look carefully at whether they were going to exclude people in order to conform to the QOF grid. However, the practice team has to be very careful in this process, as explained below:

> *'You are allowed to exclude patients from QOF, but it's not...the more you exclude the more likely you're going to be assessed or...hmm...having them looking into it...because, really…a…the best forms of audit don't have any exclusions, they just change the standards...you shouldn't need to* [do that]*…'* [GP1]

These instances of stretching the QOF's rule boundaries have become an important task for the practice team. Therefore, they need to gauge correctly and play smartly the 'QOF game' in order not to 'have them looking into it'. This context indicates the existence of a spectrum within QOF's rules that allows for gamesmanship behaviour. Although it is difficult to quantify this behaviour, it seems to represent a considerable part of QOF data make up. One member of managerial staff used the term 'massively' to describe it:

AHN: *I've also read on the literature about gaming the system, is there room for that …in QOF?*

MF5: *A lot of different practices game the system…hmm…massively…now, Dr* ['GP']*…he is not keen on that at all…hmm…it will happen a little bit…hmm…((long pause))…I think it's a fine line, isn't it? Hmm…because, let's say, if you do get investigated, which there's a chance, you could...hmm…you have to be very careful…*

Gamesmanship is a controversial, emotive topic as words or phrases like '*massively*', '*it will happen a little bit',* and '*you have to be careful'* show that this behaviour is integral to QOF data production. As I continued the conversation with the managerial staff member, I explored what sort of gamesmanship behaviour QOF allowed. Our conversation highlighted two very important ones: coding issues and exception reporting:

AHN: *But yeah, for example…hmm…what sort of 'gaming' QOF allows, for example?*

MF5: *I know, some of* [other] *practices…hmm…they've possibly done things that we may not have done here because Dr 'GP' …wasn't happy with that…sometimes, with certain things with depressions…hmm…if the reviews are done at hospital they might put that down as the review done, whereas it should be really done in practice, so it could be…you know…whether patient's seen…hmm…with the sort of depression and things like that…changing entries to low* [mood], *you know, putting a low mood rather than a depression…hmm…that's I know, that's the sort of things that probably would happen…would get done…so, a lot of it…may be…looking at coding…hmm…and I think that's probably the biggest one…is…codes and how you put them on, so that sort of things…may be changing a code, so, it's not the actual diagnosis...hmm…until they've been referred to certain tests, so…*

AHN: *So, it depends most on the honesty of the people and how…to play the QOF rules in order to…to organise things in a way that doesn't call much of attention…*

MF5: *Yes, I think a lot of exceptions as well…*

AHN: *Exception reporting?*

MF5: *Some practices…hmm…some of the reasons that they may except patients…it…may not be…hmm…sort of legitimate reasons*[5] *…*

[5] Legitimate reasons refer to the accepted exception reporting rules, as discussed in Chapter Two.

Intrinsically, the pay-for-performance modality poses conflict of interests, which naturally induces gamesmanship behaviour. The £-QOF conditioned by things that practices must do in order to generate their revenue, almost inevitably distorts the relationship with patients. Therefore, the objectives of a healthcare service get skewed and targets become a fetish that practices need to get. The following dialogue is split in two blocks. The first illustrates the flip side of this monetary quality scheme to gamesmanship. The second reveals the nature of QOF as a system that can be manipulated:

> ***AHN:*** *And what's the risk of doing this? What…what do you think are the…*
>
> ***N4:*** *You mean the risk of the QOF?*
>
> ***AHN:*** *Yes, of dangling a carrot, because I think, the idea of having some prompts…to care for the patients is good in itself, but when you put …*
>
> ***N4:*** *Yes, but when you put the money to it…*
>
> ***AHN:*** *Yeah, what…what's…the…the dark side of this?*
>
> ***N4:*** *…the dark side, I think…I've worked in a lot of other practices…and some of them… without being like…..but they make them up…so they get all the money…but they really haven't seen the patients…and they haven't done their 'QOF stuff' that they were supposed to do…*
>
> ***AHN****: But how…how do they do this?*
>
> ***N4****: They cheat!*

Despite the rise of audit culture and its practices of verification (Strathern, 2000), honesty and moral integrity still have a relevant role in data quality. This implies that trust in professional ethical integrity has to be acknowledged as an integral part of the quality scheme. However, the system is open to abuse:

> ***AHN:*** *Oh…but what…what in the system <u>allows</u> this* [cheating behaviour]?
>
> ***N4:*** *Hmm…the smaller practices could do it, but the bigger practices can't because we have far too many patients to actually* [do it]*…(.hhh)…hmm…but sometimes they…they can make a telephone call or they can say they've done this…(.hh)…and they haven't done it…hmm…but that's the system, because they've done that…like I said, they set* [referring to

the targets being too high], *I think, it's the smoking where they set the target to 100%…hmm…you're not going to see all your patients!…*[Do] *you know what I mean? Because some patients never ever come to the surgery…hmm, so for these surgeries that there are…not all of them…but some of the high…*

***AHN**: …achievers…*

***N4:** …QOF target achievers…hmm…I would say some of them do cheat. And they can do it…hmm…simply by saying that they've seen the patients, that they've done it, you know…when really they haven't seen the patients…*

***AHN**: Yeah, I know, I think there is a…the…the system is open to…*

***N4**: To abuse…*

***AHN**: …to abuse the…the system, according to…because…at the end of the year…it's a lot of money that…hmm…the staff…the premise depends on to carry on things, according to* [QOF]…

As discussed previously in Chapter Six, the restrictive deal embedded in the QOF "*you're going to get this if you do this*" distorts the nature of general practice. Besides, the annual timeframe of the QOF scheme clashes with the continuity of care (longitudinal) ideal in primary care (Starfield et al., 2005). This primary care characteristic would normally allow more room for both health staff and patients to accommodate their needs. Nevertheless, with the QOF everything has to be accomplished in a year timescale.

The previous dialogues always refer to third parties or other practices as doing the sort of behaviour that could be classified as gamesmanship. This way of talking about others gaming the system was similarly observed by Campbell et al., (2011). The same pattern was found in another study where 'few' participants 'admitted to occasional data manipulation to maximise practice incomes, and several voiced suspicions that others did so' (Maisey et al., 2008, p. 137). However, this behaviour might be common place, varying from coding issues, exception reporting, to doing QOF over the phone and so on. Hence, what follows explores the practice of gamesmanship.

THE PRACTICE OF GAMESMANSHIP

I shall now go on to examine some of the approaches to QOF that can be framed as gamesmanship behaviour. This is presented and discussed in the following subtopics:

- The use of the phone to overcome some difficulties to reach QOF targets.
- The use of software 'shortcuts' such as free-text and auto-consultation as a way to avert damaging to the practice's QOF profile or to reduce the QOF chores.
- Exception reporting as a gauging mechanism for adjusting to QOF targets.
- Coding amendment strategies to avoid losing important QOF points.

To understand the potential ways of making up QOF data by exploring different aspects of this quality assurance scheme, might contribute to highlight possible consequences for general practice principles, professionals' behaviour and data quality production. Apart from Swinglehurst and Greenhalgh (2015) ethnographic study, evidence on how QOF data are produced in general practice is almost absent.

Doing QOF-tasks over the phone

Doing QOF-tasks over the phone is one of the general practice's key chasing strategies to get some QOF points. However, this can clash with the 'best practice' ideal of EBM, as further discussed. To illustrate this behaviour I shall divide it in three parts: (1) phone as exception reporting through patients' dissent; (2) phoning to extract patients' token-information; and (3) phone consultations for QOF clinical targets and reviews.

Phone as exception reporting through patients' dissent: the rheumatoid arthritis case

Phoning patients carries the potential of not finding them at home and might be more human resource consuming, whereas letters of invitation might involve less staff time commitment. Nevertheless, if the patients are contacted by phone, they can straightforwardly decide whether to accept the invitation or not. If the patients decline the invitation, the receptionists can put this information on their record.

These patients can later be excluded from the denominator, since they will be recorded as a 'patient dissent'. The phoning strategy can be used to maximise the points for

'hard to reach' patients. In the 2013/14 contract there were four QOF indicators for rheumatoid arthritis (RA), as shown in Figure 7.1.

Rheumatoid arthritis (RA)

Indicator	Points	Achievement thresholds
Records		
RA001. The contractor establishes and maintains a register of patients aged 16 or over with rheumatoid arthritis *NICE 2012 menu ID: NM55*	1	
Ongoing management		
RA002. The percentage of patients with rheumatoid arthritis, on the register, who have had a face-to-face review in the preceding 12 months *NICE 2012 menu ID: NM58*	5	40–90%
RA003. The percentage of patients with rheumatoid arthritis aged 30 or over and who have not attained the age of 85 who have had a cardiovascular risk assessment using a CVD risk assessment tool adjusted for RA in the preceding 12 months *NICE 2012 menu ID: NM56*	7	40–90%
RA004. The percentage of patients aged 50 or over and who have not attained the age of 91 with rheumatoid arthritis who have had an assessment of fracture risk using a risk assessment tool adjusted for RA in the preceding 24 months *NICE 2012 menu ID: NM57*	5	40–90%

Figure 7.1. QOF rheumatoid arthritis (RA) indicators. Source: BMA, NHS Employers, & NHS Commissioning Board, 2013.

Patients with RA are mostly seen by secondary care health team with GPs having the role of care coordination. For this reason, requesting patients to come for a review in general practice seemed to be a pointless exercise for the practice team. However, this perception is a 'debatable' area, as can be exemplified in the following dialogue [M1]:

> ***GP5:*** *The only ones where you can get them in…and get the points are things like when you're dealing with limited numbers like rheumatoid* [arthritis] *where if you saw five patients in* [the] *rheumatoid* [list] *you would see a difference in your points…*

AHN: *The rheumatoid it's been seen by secondary care basically, so it's quite hard to them* [the patients] *to come in…*

GP5: *Yeah, but they all have 'med'* [medication] *reviews, you know, we're working in an environment where we see patients every year. So, we've got 55 out of 90, but we've only got two months to go, so…we must have seen those patients.*

As stated above, there should not have been an excuse for not reviewing patients with RA, since they have come for 'medication reviews' and general practices operate in a way that they see these patients 'every year'.

Despite one of the GP practices' efforts to invite RA patients for reviews, it has not worked as planned. For instance, practice 'B' was having difficulties with a particular QOF target: the rheumatoid arthritis (RA) indicators face-to-face review. The Figure 7.2 shows that all percentages were in red and there were no points achieved for these QOF indicators.

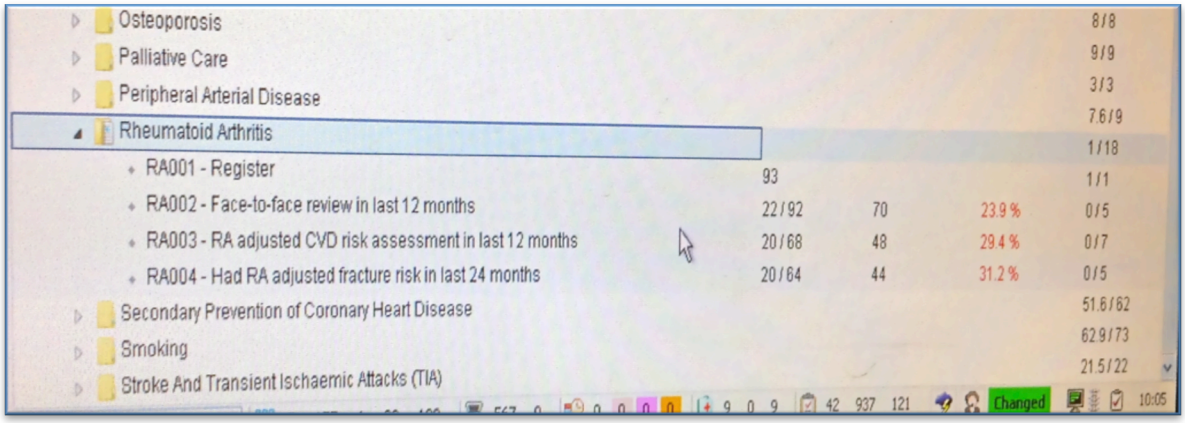


Figure 7.2. Computer screen snapshot showing rheumatoid arthritis (RA) indicators with all percentage of achievement in red.

One of the strategies adopted by the practice team to overcome their missing target patients for RA was to set up a task force: a receptionist phoned those missing patients and offered them appointments. The result was, as they predicted, very successful: most turned down the invitation. This allowed the practice to take them out of the denominator as 'informed dissent'. Thus, many QOF points were made just by phone calls and not really seeing the patients or caring for them at a practice level, as intended by QOF standards. The following dialogue in a QOF practice meeting makes this clear [M3]:

[Talking about rheumatoid indicators that needed a face-to-face review…]

MF5: *No, what we decided to do…hmm…between us is…*[RA] *face-to-face review, if we've phoned them…and this is…*

MF8: *What's this one?*

MF6: *…the rheumatoid* [arthritis]…

MF9: *All right!*

MF5: *We're still miles off…and what we're saying is that if we phone them and they say on the phone they don't want to come in then you would except them…rather than sending the letters…that's all we've done, so we've got that…that's brilliant!*

MF6: *…and* [Mrs. Receptionist's] *been quite good as well, she said: -"Well, we'll take you off the list for this year but you'll be called next year"…*

MF5: *Yeah…so now…because we've had about 30 patients to ring…*

MF6: *There was a lot…there was a lot of points in it as well…*

MF5: *That's really good, so we don't bother about that* [indicator].

The above conversation shows one data production strategy. To a certain extent, this represents practice teams' ability to play with QOF's rules and not actually offer any quality for health care services. This shows that the practice team did not consider this QOF indicator as clinically relevant since specialist rheumatoid teams were directly caring for those patients anyway. Nothing is illegal in this behaviour, but shows creative ways of dealing with QOF's rules for the sake of getting QOF points, therefore, winning the QOF game through gamesmanship.

Phoning for extracting patients' token-information: the GP Physical Activity Questionnaire

The 2013/14 contract requires the practice team to screen the level of physical activity in hypertensive patients. After screening patients' level of physical activity, they should be encouraged through a brief intervention to increase their level of activity, as stated in QOF rules (based on NICE guidance):

> Primary care practitioners should take the opportunity, whenever possible, to identify inactive adults and advise them to aim for 30 minutes of moderate activity on five days of the week (or

more). They should use their judgment to determine when this would be inappropriate (for example, because of medical conditions or personal circumstances). They should use a validated tool, such as the GPPAQ, to identify inactive individuals. (BMA, NHS Employers, & NHS Commissioning Board, 2013, p. 54)

Figure 7.3 shows the QOF hypertension indicators and the need to screen and give a brief intervention to those classified as 'less than active'.

Hypertension (HYP)

Indicator	Points	Achievement thresholds
HYP004. The percentage of patients with hypertension aged 16 or over and who have not attained the age of 75 in whom there is an assessment of physical activity, using GPPAQ, in the preceding 12 months *NICE 2011 menu ID: NM36*	5	40–80%
HYP005. The percentage of patients with hypertension aged 16 or over and who have not attained the age of 75 who score 'less than active' on GPPAQ in the preceding 12 months, who also have a record of a brief intervention in the preceding 12 months *NICE 2011 menu ID: NM37*	6	40–80%

Figure 7.3. QOF hypertension indicators related to physical activity evaluation using the GPPAQ. Source: BMA, NHS Employers, & NHS Commissioning Board, 2013.

In spite of the public health ideal to prompt patients to do more physical activities, most GPs found it a pointless exercise:

'...It's a very poor assessment tool as well, for example, if you've got someone who is a hill walker, walking doesn't count, it makes absolutely no difference to their score!' [GP3]

[or]

'The actual score...we...I almost entirely leave that all to the nurses...we've decided in our practice to do as much as we can bear and then stop: "- Keep your sanity first!" So, are the nurses doing it? I believe they are, but I've stopped doing them...I'll do them if I had time but I never do so... I mean...' [GP1]

As the above quotations suggest, GPs tend to hand this activity over to other members of staff. In practice 'B' not only health staff members were doing the GPPAQ; receptionists or administrative staff were doing it over the phone as well. They can access patients' records, open the patients' notes, and then click on the icon that brings the GPPAQ template to guide the enquiry into a patient's activity level. The GPPAQ template questionnaire is organised into three areas: (a) physical activity at work; (b) physical exercise; and (c) walking pace (Figure 7.4).

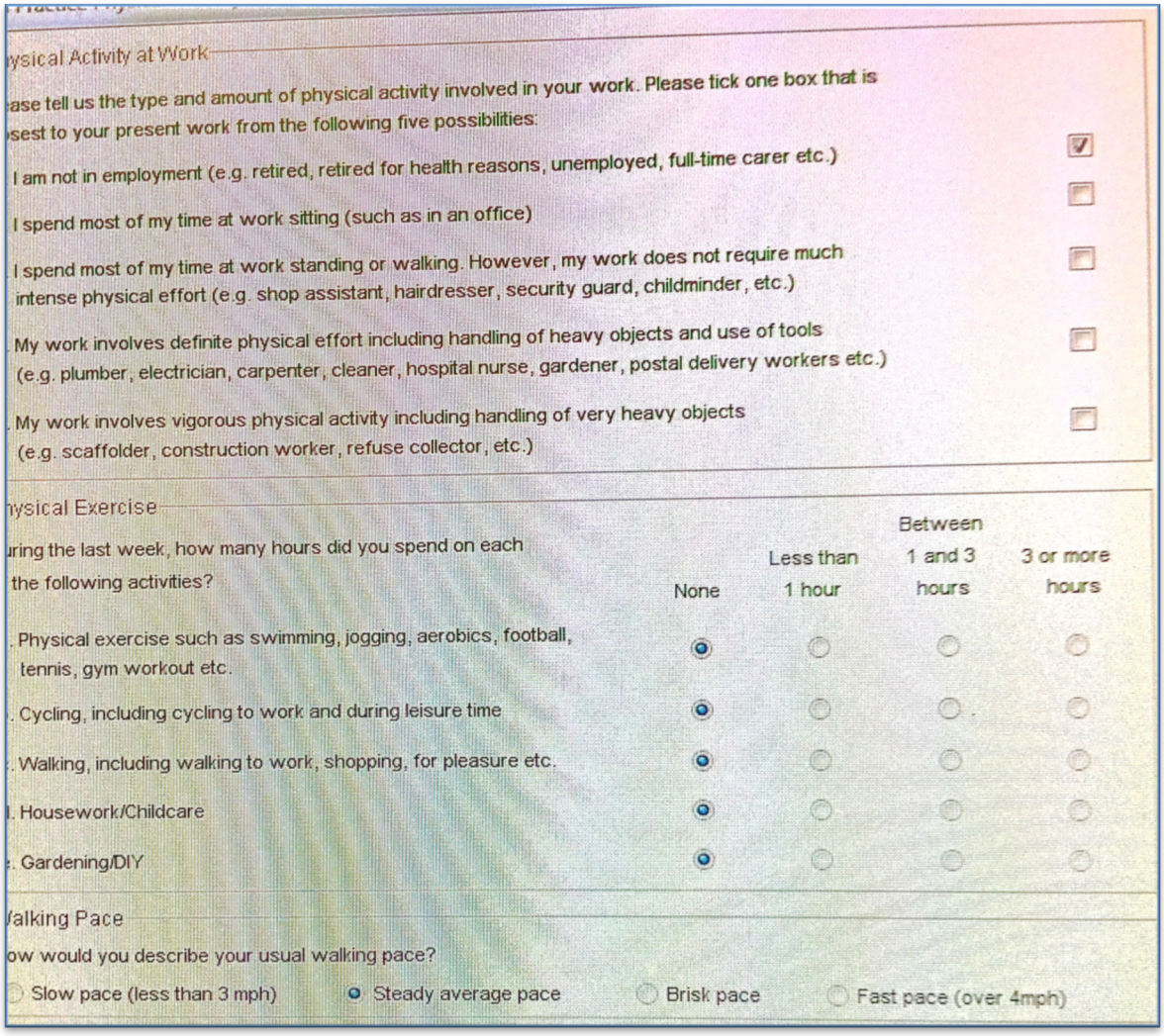


Figure 7.4. GPPAQ template for assessing patients' level of physical activity.

This afternoon observation occurred in practice 'B's administrative working area. One of the managerial staff was absent that day, allowing her space (desk) to be taken by an administrative member of staff to go over a list of missing patients that needed the GPPAQ

done. The administrative staff went through a repetitive standardised questionnaire allowing me to take notes of the key aspects of this QOF-phone task.

In general, the phone inquiry started with the receptionist or administrative staff identifying that the phone call was from the GP surgery (i.e. – 'Hi, it's the [surgery name] calling'). The justification for a telephone call was referred as a matter of updating the patient's record instead of explaining that the GPPAQ was required in accordance with the pay-for-performance scheme. Asking if it 'would be OK to do some quick questions over the phone' facilitated patients' agreement. Once the administrative staff received a patient's consent, she would then formerly start the GPPAQ template over the phone.

The receptionist would commence the questionnaire by asking if the patient is 'currently employed at the moment' and if yes, would classify the type of patients' physical activity level at work. In sequence, she would then ask about any other physical exercise: - 'Do you swim, jog or play football, anything like that'? Finally, ask about the patient's usual walk pattern: 'slow, steady, brisk or fast?' The ending of the enquiry was generally like: – 'Right, okeydokey, that's all I needed to know, thank you for your time, bye.' In most of the cases, patients would turn out to be inactive, but this would not prompt her into offering advice or any strategy to stimulate the patient into becoming more active. In other words, it is a purely tick box exercise for the purpose of doing the designated QOF task.

Phoning for extracting patients' token-information exemplifies playing with the 'QOF game' to generate data. Most of members of staff just framed this as a 'waste of time', but carried on doing it because receptionists were powerless to refuse to do this activity as employees. I also witnessed the same attitude towards smoking 'advice'. The receptionist went through the equivalent procedure justifying her phone call as being done to update patients' records. As Heath (2010, p. 92) points out:

> Advice to stop smoking is proportionately more powerful when it is linked to an episode of acute bronchitis or a first presentation of angina. In contrast, the blanket application of preventive imperatives poses a grave threat to authentically person-centred medicine.

The QOF phone-checking activities such as smoking 'advice', GPPAQ, dietary reviews, mental health reviews, and erectile dysfunction in diabetes review, can all be seen as both playing the 'QOF game' (organising staff in a way to hit the targets) and gamesmanship, since these phone activities might rather be questionable ethically or even medically (Heath,

2010). These issues are exemplified in the following dialogue about erectile dysfunction in diabetes review and phone consultations on dietary advice for diabetic patients.

Phone consultation for QOF clinical targets and reviews: the cases of erectile dysfunction and dietary review in diabetic patients

Erectile dysfunction: according to QOF standards, male diabetic patients should be screened by health staff about their erectile situation, as can be seen in Figure 7.5 below:

Diabetes mellitus (DM)

Indicator	Points	Achievement thresholds
Records		
DM015. The percentage of male patients with diabetes, on the register, with a record of being asked about erectile dysfunction in the preceding 12 months *NICE 2012 menu ID: NM51*	4	40–90%
DM016. The percentage of male patients with diabetes, on the register, who have a record of erectile dysfunction with a record of advice and assessment of contributory factors and treatment options in the preceding 12 months *NICE 2012 menu ID: NM52*	6	40–90%

Figure 7.5. QOF erectile dysfunction indicators for male diabetic patients. Source: BMA, NHS Employers, & NHS Commissioning Board, 2013.

The issue of erectile dysfunction was being monitored at the managerial level (as discussed in a nurse meeting on Chapter Six). Clearly, some members of staff were not comfortable asking patients about it. For example, the conversation in one QOF meeting, where all participants were female apart from a GP, went as follows [M3]:

N4: *I know the erectile dysfunction is still a problem…*

MF7*: Me and* [she] *are doing that…I'm up to November…*[inviting patients in]...

N4: *Hmm…they still don't ask them and it's been brought up in the nurse meetings…*

MF5: *Why they are not asking them? Are they not comfortable asking them* [patients]*?*

N4: *I don't know, I think, that's probably* [the case]*…unless they just forget…*

MF5: *You have to try and get over that…*

GP11: *But it's on the template…*

N4: *I know, I know…*

MF5: *Is there anyone in particular or…*

N4: *Mrs.* [Nurse]…

GP11: *You have to tell her and speak to her about it…I know it's coming out next year, but we still need to do this year…*

MF5: *We've got to try and hit as much as we can…*

N4: *I can phone them and ask them, that's not a problem…*

GP11: *Yeah…*

N4: *I don't have an issue with it…*

The above dialogue illustrates how uncomfortable some members of staff clearly were with asking diabetic patients about erectile dysfunction and the potential for name and shame. Moreover, the practice knew that this indicator would be retired for the next contract, but they needed to keep performing it for the ongoing contract year (BMA, NHS Employers, & NHS England, 2014). This shows the QOF targets being treated as technical-bureaucratic things and not by their clinical relevance. As discussed in Chapter Six, it illustrates the top down nature of QOF and its effects on professionals' autonomy conflated by potential monetary gains that stimulate staff's 'internal motivation'. This process tends to prompt self-interested behaviour patterns over any higher professional core values.

At end of the financial year, 'missing patients' accumulate, prompting to gamesmanship practices such as the use of phone consultations. I spent a whole morning observing a set of nurse phone consultations, put in place just for the sake of hitting some QOF targets for diabetes. In order to optimise her time other diabetes-related requirements were included such as dietary review and erectile dysfunction. The following conversation extract narrates this activity:

AHN: *What bit of the QOF are you doing?*

N4: *I'm doing…hmm…ringing around patients…for the 'diabetes stuff'…hmm…erectile dysfunction…and…the dietary advice…*

AHN: *So, you are doing this over the phone…*

N4: *Hmm-hmm* [yes]…

AHN: *OK.*

She then produced a list of activities for that morning, targeting the missing patients, and explaining to me her strategies for optimising the time:

N4*: Right, now I want to go to: "end of year"…*[then] *"diabetes"…right, what I've got?…"dietary review"…I've got 89 patients…to ring and the reason why I picked the diet…because some of the diet ones…I wouldn't search into the erectile dysfunction* [first]…*hmm…that one there* [showing the QOF indicator on the screen], *but some of them have dietary* [review] *as well, so rather than…take the chance of ringing them twice…go straight into erectile dysfunction and find: "-Oh my God! They need dietary advice as well". So, what I've done, I've gone to the diet first…*

AHN: *Yes, because you can…hit both in one call.*

N4: *And I also need to ring…some mental health this morning, retinal screening as well…*

Her strategy of starting firstly with female patients and dietary requirements, coupled by the number of patients in need of review (89), meant that I could not observe how she addressed diabetic patients about erectile dysfunction over the phone. As she did not manage to go over the whole list, possibly she would need more sessions to cover all the QOF-tasks.

Diabetes dietary review: QOF has a requirement for diabetes review, which states that almost all patients with diabetes registered in a GP surgery should have a dietary review with a trained professional (Figure 7.6). As an example of how this review is done over the phone I shall present one case of phone consultation and one pre-phone consultation addressing the diabetic dietary review requirements. In the case of the first patient, the full phone-consultation will be divided into four steps: (1) the pre-consultation; (2) the opening of the phone-consultation; (3) the actual dietary review; and (4) the closure of the phone consultation. The pre-consultation illustrates the dialogue between the nurse and me while she verifies the patient's QOF targets and the needs attached to each one of them by looking into the patient's notes.

Diabetes mellitus (DM)

Indicator	Points	Achievement thresholds
Records		
DM013. The percentage of patients with diabetes, on the register, who have a record of a dietary review by a suitably competent professional in the preceding 12 months *NICE 2011 menu ID: NM28*	3	40–90%

Figure 7.6. QOF dietary review indicator for diabetic patients. Source: BMA, NHS Employers, & NHS Commissioning Board, 2013.

[Step 1 – the Pre-consultation]

N4: [Talking to herself as she looks into patient's notes]… [This lady], *so Mrs XX's got…she needs the blood pressure as well…tchu, tchu, tchu…and a diet review…##...look at her bloods 5.1* [cholesterol], *what's she on?…She's on anything…no sensitivity, so why isn't she on statins?…Hmmm…tchu,tchu,tchu,tchu…so, she should be on statins there…she needs a blood pressure done, CKD* [Chronic Kidney Disease], *and she's been seen…recently…*

AHN: *Has the blood* [test] *been repeated? Because it's quite…close to the target, because it's 5.1*…[target is below 5.0]

N4: ...*Hmm…but, she should be on statins anyway…she is diabetic…*

AHN: *But even if the cholesterol is within the target?*

N4: *If the cholesterol is five I would simply put somebody on statins…because they're recommended for diabetics over 50 is…statin…and…*

AHN: *Regardless the level of…of the cholesterol?*

N4: *Yeah…she must be housebound…so, she must be housebound*…[scrolling up and down patient's electronic record]…

AHN: *She is 82, anyway…*

N4: *...Hmm…*

AHN: *Does she need statins?*

N4: *So…so the district nurse is going there…hmm…now we've got…we need a blood pressure… less than 140/80…(.hhh)…and she needs a statin…*

AHN: *Despite her age? 82* [years old]…

N4: *Hmm-mm* [yes]*…hmm…*[it] *depends on what her diet is, <u>really</u>, because if the district nurse is going in as well I don't…*

This conversation reflects a quite decontextualized approach to diabetes care focusing on targets with a concern to fulfil QOF criteria: *'she needs statins',* despite being an 82 year-old patient. This exemplifies the very target driven QOF-induced behaviour that does not contextualise a preventive action in relation to patients' age, health conditions, cultural and family values, etc. Similarly, McGregor et al. (2008, p. 711) found a 'negative effect of the QOF on holistic care, including ethical concerns and detrimental effects on the patient–nurse relationship, which were regarded as a core value'. This is further illustrated by the opening of the consultation, which starts with the professional introducing herself to the patient, explaining the reason for calling, and then moving to check why the patient is not on statins:

[Step 2 - the opening of the phone-consultation on dietary review of an 82 year-old lady]

Hello Mrs Lady. Alright, it's the nurse…from [the surgery]. *I'm just enquiring…something is wrong with your diabetes, which we just need to check…Hmm-hmm…yeah…I noticed that your cholesterol was raised slightly, but they haven't been putting you on statins…right, I can put that down then…emm…right, did he?…What I'll do is…knowing your sensitivity…*[thinking what she was going to do, but actually not expressing it]*…it does… that's probably why…emm…*[N4]

After checking patient's statin intake and realising that she had some side effects, which then would satisfy QOF's exclusion criteria, she moved on to the second part of the 'over phone' dietary review:

[Step 3 - the actual dietary review]

[Continuing]*…hmm…and the other thing is just looking at your diet…looking at your diet…hmm…what sort of food do you eat? Obviously, because your cholesterol could be raised because of what you eat…right…hmm-hm…right…what do you have for your breakfast?...*[listening to the patient]*…what sort of things do you have for your breakfast?…with semi-skimmed milk…and no sugar…how about your lunch?…..right…hmm-hmm…what are you eating in the middle?…right…and…do you have any cakes or biscuits or?…right…how often do you have that?…right…is that every day?...right…hmm…and what about, obviously…must be a little bit immobile, if you like, you don't leave the house…right…God, that's a lot of weight lost, isn't it!? Hmm-hmm…right…well, you've done <u>well</u>, you've done really, really well…yeah, I mean your diet doesn't…Do you grill most of*

your food as well when you have a meat?…right…and what about fish? Do you eat any fish?...right…((slightly laughing))…right…right,…[N4]

To finish the phone consultation the nurse returns to the theme of statins reassuring the patient that she will write down her sensitivity as well as her diet profile. In the conversation she gets the information about the patient's blood pressure, which is linked to a QOF target.

[Step 4 - the closure of the phone consultation]

'Hmm…well, I'll put the sensitivity to the… to the statins on your notes…so they don't offer you it again…and then I'll just document all your diet stuff…oh…yeah…do they give you anything? ...right…right…hm-hmm…oh!...painful…hmm…oh, yeah…tch, God…right, so is [the nurse] *coming in to you…right, when is* [she] *due back in?…oh, did she?…what was the…so, what was it? Say 140…hm-hmm* [over] *57?…all right…*[blood pressure]*…OK, so I'll document all that for you…hm-hmm…so…yeah…so, do you do your own every day?...yeah…right…oh, were you?…((laughing))…right…yeah I've noticed that, yeah…but I'm not going to put you on… statins obviously because you've had a reaction to it before…Did he?* [Someone knocks the door]*…well, right I'll put it in obviously you had a reaction, what sort of symptoms did you get? Did you feel sick? Did you get any aches and pains or? Right, right, yeah, OK…I'll document that then…and your diet and everything and then everything is done…'* [N4]

The above phone consultation highlights how guidelines become protocols with the loss of peripheral thinking, losing context and the holistic approach. According to McDonald, Campbell and Lester (2009a, p. 1209) the 'adoption of computerised templates, which guide nurses through the consultation facilitating data collection for the new target-focused culture, was seen by many as changing the consultation process in a way which threatened the delivery of patient-centred care'.

The phone consultation illustrates the intrusive aspect of the QOF approach to care. The nurse justifies the phone call because: - 'Something is wrong with your diabetes'. In fact, nothing was wrong with patient's diabetes, but she needed to put the evidence into the patient's notes in the form of retrievable information to say the patient had been exempted from statins and reviewed for her diet according to some protocols.

The QOF scheme does not state that it should be a face-to-face review in a contextualised patient-centred approach, thus, it is not illegal, but from the ethical and

medical perspective, is this really 'best practice'? This characterises a sort of gamesmanship behaviour just to produce the data required in order to win the 'QOF game'. The quality or patient-centeredness of the case involved becomes irrelevant.

The following pre-phone consultation conversation reinforces the type of medicalisation process introduced by QOF into the primary care services. Needless is to cover the whole consultation and diet, as in the first case. Enough is the preliminary dialogue with the nurse:

> ***N4:*** *Now, this other one, it's probably housebound* [looking into patient's notes]…
>
> ***AHN:*** *84, yeah, definitely…*
>
> ***N4:*** *Hmm…right…*[it] *looks like she is housebound as well…..yeah…so going there, dietary advice…and say again cholesterol, I want to exempt her…hmm…*
>
> ***AHN:*** *She's* [already] *on statin…*
>
> ***N4****: …cancel…hmmmm ((long))…repeat… is she on simvastatin?*
>
> ***AHN:*** *Hm-hmm…*[yes, checking on patients note]…
>
> ***N4:*** *It's that she has no evidence, so again, yes, it's because she has no evidence…that's why it is…*
>
> ***AHN:*** *Because she hasn't done the bloods* [Blood tests].
>
> ***N4:*** *Hm-hmm* [yes] *which I'm going to download…from the hospital to see if she has some done in the hospital…*[starts to look for evidence on patient's records for laboratory results from the hospital]*...she had a CT* [computerised tomography]*…glucose in* [MM]*…for this…this is knees and bones…TSH* [thyroid stimulating hormone]*…(.hh)…* [DD/MM]*…this was last year, so she needs that done…hmm…so, what I can do is to get the district nurses, they'll do it…to do a cholesterol…so, she needs the cholesterol, the dietary and the foot examination…so, hmm…(.hh)…so she needs…hmm.*

The above dialogues illustrate an impersonal type of care focused on diseases and on pre-determined patient needs. As Checkland et al. (2007, p. 696) remark 'records based upon a system of clinical codes will tend to concentrate on technical and physical aspects of care that can be reduced to binary information (yes/no, present/not) and ignore more qualitative data required for "reflective practice"'. This is the new type of instrumental culture that is growing in nurse-patient relationships.

What is the purpose of such preventive activities? What are their implications for the health and wellbeing of the elderly ladies involved? What is the impact of checking peoples' diet over the phone in terms of preventive action? What is the justification for diverting a very qualified nurse to carry on such a 'waste of time' QOF-task over the phone? In this context, QOF disease management symbolises a fragmented, protocol-driven, decontextualised, intrusive and ultimately purposeless health activity (Gérvas, Starfield, Violán, & Minué, 2007). The answer to these many questions could be attributed to QOF's commercial approach to patient health care. Patients become commodities, with multiple-comorbid elderly patients one of the most lucrative to clinical groups because they bear many QOF points. I explored this issue with a managerial staff:

> ***AHN:*** *In terms of point making, do you think…hmm…there's a special patient that brings more points for the practice?*
>
> ***MF5:*** *There is…hmm…in the QOF lists you have some…you have 'target patients'…hmm…area, they will give you the patients that have the most outstanding points and the more…and how much that patients would cost if you've got them in reviewed. So, we do target them as well, we look at those…we try to get them in throughout the year…hmm…most of them…hmm…quite a lot of them are housebound…so, as well as just doing…the reviews for patients we look at those 'target patients' that are going to bring more money in the practice as well.*
>
> ***AHN:*** *So, do you think that people who are housebound are very good patients to target?*
>
> ***MF5:*** *A lot of them have more than one chronic disease, they have multiple problems…hmm, but housebound are quite difficult at times, because obviously, when you try to get everyone into the practice…you can see a lot more in practice than you can if you send a clinician out…hmm…so, we're gonna try to get district nurses more involved from next year…hmm…*

I visited three nursing homes while doing my fieldwork, either with GPs or nurses, as they went there for 'QOF stuff' as well. It seems to me that the elderly are a kind of 'easy prey' with little agency and great dependency, sometimes, relying on a third person for decision-making (e.g. a relative). In one visit to a nursing home I noticed that flu vaccination consent was asked, but apart from that the trend was to agree with doctors' requests, for blood tests, medication and so on, without any question being asked. So, frail, housebound elderly people can be quite lucrative for general practice. Thus, the motivation for doing QOF things carries an inherent conflict of interest with GP principles.

Software 'shortcuts': free-text and auto-consultation

As previously mentioned in Chapter Four (p. 103), practices to a certain degree can customise their software default and templates. What follows give example of the software operational characteristic and flexibility that help practice teams in shaping the data production.

Playing with Free text and QOF Read codes

The System-One software allows health staff members to write in either Read code format or free text. The former must enter on patient's notes for registering and QOF data retrieval, as well as for an audit process; the latter makes the recorded information not QOF-retrievable, so that it is not picked up for QOF purposes. As shown in Chapter Four (p. 97), health professionals can choose QOF Read codes as they type into patient's records while the computer activity offers various options. Since, I had been observing some of the free text behaviour I wanted to confirm this by formally asking about this particular issue. When I was interviewing a member of managerial staff I introduced the issue of free text as a QOF points management strategy:

> ***AHN:*** *Three things that I've observed that I would like you to give me some feedback, if it's possible: one is the free text versus coding text. How this can help sometimes in terms of point management?*
>
> ***MF5:*** *Right, I'm not quite sure what…*
>
> ***AHN:*** *I saw that sometimes instead of writing the BP* [blood pressure] *as a coding we write it as free text, for example…*
>
> ***MF5:*** *We should <u>always</u> code them, but <u>if</u>…you…come to the end of the year…hmm…I mean, basically we should <u>always</u> code them…hmm…if it's a high BP reading…and this is the first time of BP reading…it's hard…you might put in free text rather than code because that would not come on your* [QOF]*…it will not flag up on your QOF, as…hmm…high BP. You shouldn't really do that…you should code them…hmm…it's…hmm…*
>
> ***AHN:*** *It's a grey area…*
>
> ***MF5:*** *It's a grey area…*

Once when shadowing a GP consultation, at the end of the morning session there was an opportunity for a brief interview about QOF and on gamesmanship:

> ***AHN:*** *I've been observing, for example, that you can* [write] *as free text or you can use the Read code. One is extracted for audit purposes and also for…QOF…and the other is not…for example, the blood pressure…out of the target and it may damage…the previous reading or…*
>
> ***GP9:*** *Well, I've done that today, actually…hmm…a blood pressure who…came for a medication review…her blood pressure was being very well controlled…hmm…but it was high eventually today and I, in fact, free text it today just to…hmm…to not to…*
>
> ***AHN:*** *I found…I found quite a normal thing…but in some way prevents the…hmm…QOF being damaged for that particular target…*
>
> ***GP9:*** *Yes, it works for that target, but then, I guess an internal reviewer couldn't go back through the* [blood pressure] *readings…that wouldn't appear as…because you can work on previous blood pressure readings, but if you're not putting in certain ways that wouldn't…wouldn't come up…so, I guess, from that point of view it's not so good doing it…*

This free text behaviour was observed by Swinglehurst and Greenhalgh (2015, p. 6) agreeing that from the quality data perspective this behaviour makes it 'more difficult to find [information] in future consultations (and 'invisible' to any audit process)'. On another occasion, during a practice meeting, a GP advised colleagues to use a free text smartly in order to facilitate the work and not mess things up. Thus, I later on inquired about this issue and the GP answered as follow:

> *'Yeah, so…it's stupid for us to put it that down as 141/91…it just fails…and I'm not going to do anything about it…we've said, we shouldn't be changing their medication for it…hmm…but similarly…we should be checking…you know, one of the arguments has been…if someone's blood pressure is normal and one of those was* normal [referring to a patient we saw together]*...and when I did it was* <u>*abnormal*</u> [when he checked]*...you* <u>*can't ignore*</u> *the fact that the blood pressure is high because it messes your QOF…you know, so…yeah…I'm…I did some guff things and some good things, but…so…'* [GP13]

Hence, QOF creates artificialities, which health staff have to play with in order to generate their income. This gamesmanship behaviour helps to make up the data to comply with QOF requirements. The extents to which this behaviour play a role in practice overall QOF point's achievement is questionable and may occur as the practice reach the end of financial year:

AHN: *Other gaming that…maybe it's not gaming…but I think the system allows a lot of trust on the person…because as you say, a 141…why not to record* [a blood pressure] *as 140 or 139 because two points wouldn't…and this is difficult to audit…*

GP5: *That might happen if you get to March…and the doctor takes a blood pressure and if it's 141/85…he might record it as 140…hmm…but I think that's a small part…of the gaming process, because the nurses would never do that…and there might be a few doctors that do that, but they probably only do it in March…*

AHN: *They wait…they wait to so see at…how much…how much or…*

GP5: *Well, the thing is, there's so few patients…it would have little influence, so the eleven months of totally genuine blood pressure readings would far outweigh the small minority who turn up towards the end of March…so, fiddling the blood pressure readings at that point it's not worth it, because it has…it's a drop in the ocean…hmm…it's not going to make any difference…*

AHN: *Hmm…OK.*

It is difficult to evaluate such behaviour and its influences on overall data production. Nevertheless, the very need to do it just for the sake of point achievements is in itself a distortion that otherwise would not necessarily have happened.

Auto-consultation: a short version clinical review

The auto-consultation shortcut is a way to generate the required Read code for a particular QOF indicator that dispenses the practitioners to go over the whole disease template. I have just managed to get this information because a GP explained it to me while I was attending a clinical session, otherwise it would be almost impossible to me, as an observer, understand that a 'complete' clinical review was performed in one 'click'. What follows is an account based on my fieldnotes.

In January 2014, the GP was consulting a 48-year old male patient with a bad cold, chest pain and cough. The GP performed a chest examination, in which he could not find any sign of complications such as pneumonia. The diagnosis was framed as bronchitis to which he prescribed a course of antibiotics, though there was no guaranteeing that the antibiotic would improve the symptoms, as the likelihood was of a virus infection. As the GP pointed out 'things would eventually clear up anyway'. After the patient left the consulting room the GP made the following remark: '*I did to this patient an asthma review for QOF'*. I said: -

'*What*?' He replied: '*I've done it opportunistically because this patient won't come again. He is a healthy man and it is difficult to reach this kind of patient. They simply won't come again*'. But I replied: - '*You haven't gone through all the template*'. He then said: - '*No, I haven't. So, because this patient won't come, but I know that he is fine. You can see this by the number of inhalers he ordered a year*' (showing on the computer screen that the patient's medication usage displayed a good pattern of disease control). He then continued: - '*This shows how good his asthma is; and there are a lot of asthmatic patients in the same situation. So, you have to do a review that is not the "standard", it's kind of "short version", but you have seen the patient, he's been here and he is doing well regarding his asthma control*'. '*But how you did the review*?' I questioned. To which he replied: - '*If I just use this auto-consultation, it will bring the whole coding necessary for the asthma QOF points without needing to be specific and/ or go through the templates. It's a bit of gaming, but otherwise we won't get the points*'.

As Rose (1992) argues disease has been framed in medicine as a continuum of risk and severity, though most patients' severity status lies between mild to moderate. This produces a challenge to the practice team to bring this kind of patient in to a clinical review.

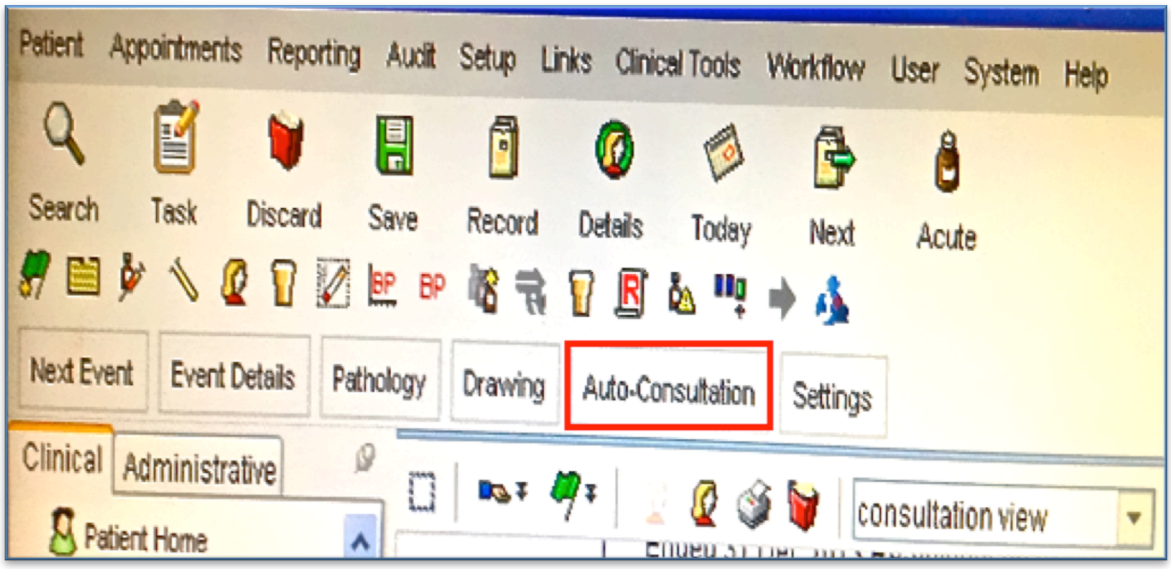


Figure 7.7. Auto-consultation icon that allows for a 'short version' of clinical reviews.

The shortcut 'auto-consultation icon' (Figure 7.7) helps practices to generate the data, when the patient comes in for other reasons, and health staff have some indirect ways of assessing their chronic disease control, as in the case of medication pattern usage. The Read code is

generated when the patient is in the practice, therefore, an audit cannot differentiate if the patient has gone through a whole template type of clinical review or not.

Exception Reporting: adjusting to the targets

As stated in Chapter Two, QOF allows for exception reporting, since it recognises that not all patients will be suitable for medical interventions either for clinical reasons or because patients refuse the treatment offered. The former is usually described as 'patient unsuitability' or 'on maximum tolerated treatment' and is based on clinical judgement (discretionary); the latter is labelled as 'informed dissent', and therefore, non-discretionary (Campbell et al., 2011). Informed dissent plays a great deal in the 'QOF game', as described above with RA patients, who were coded as 'patient dissent' after some phone calls.

Another strategy for excluding patients from the denominator is to document those who did not attend (DNA), despite having received three invitation letters. Thus, piles of letters are sent to patients and a whole administrative task force is put in place to guarantee that letters are sent in due course.

I spent some time with the administrative staff folding some of these letters and putting them in envelopes. One of the tactics is to link the invitation letter for annual reviews with the patients' birthdays, as described in Chapters Three (p. 52) and Six (p. 151). The administrative workload involved in this is tremendous, as are the costs of keeping patients on track, as expressed by a managerial function staff:

> *'...Cost wise...hmm...cost has increased because there's always lab tests that you have to do* [now] *and you didn't have to do them all* [in the past]*...postage costs...which cost a fortune now...hmm...you have to send at least three letters if they* [patients] *don't reply, you know...hmm...there's all the admin* [work] *around that...'* [MF4]

In spite of this chasing strategy, it is common to have quite a high ratio of informed dissent. A GP explained that diabetic patients have particularly high rates of exception reporting, either because they do not engage with the diabetes clinic or because they refuse (informed dissent) to take insulin, for example, or they are on the maximum tolerated treatment.

For instance, diabetic patients' profiles, in this case, would be those on maximum insulin, under a hospital specialist care, attending a regular diabetes clinic, who still have not achieved good diabetes control. This would be a reasonable scenario to except the patients for

the QOF indicator that specifically deals with 'diabetes control'. As the exception reporting is target specific, the practice would not take the patients off from the diabetes register, but only would exclude the diabetic patients from the diabetes control component (i.e. the level of haemoglobin A1c – HbA1c). The diabetic patients would still need to have good blood pressure control, cholesterol control, feet care, dietary care, and so on, as part of the diabetes whole care package. However, when it comes to 'the bit' of the QOF that measures diabetic control (i.e. HbA1c levels), the QOF timeline will highlight the changes in colour: '*It will go grey, it won't go red or green, and it will go grey',* as one GP put it. This means that a patient was excepted for that particular target. Figure 7.8 exemplifies a patient who has been exempted in four QOF targets, which have turned into grey: asthma, newly diagnosed depression, proteinuria or micro-albuminuria, and influenza immunisation.

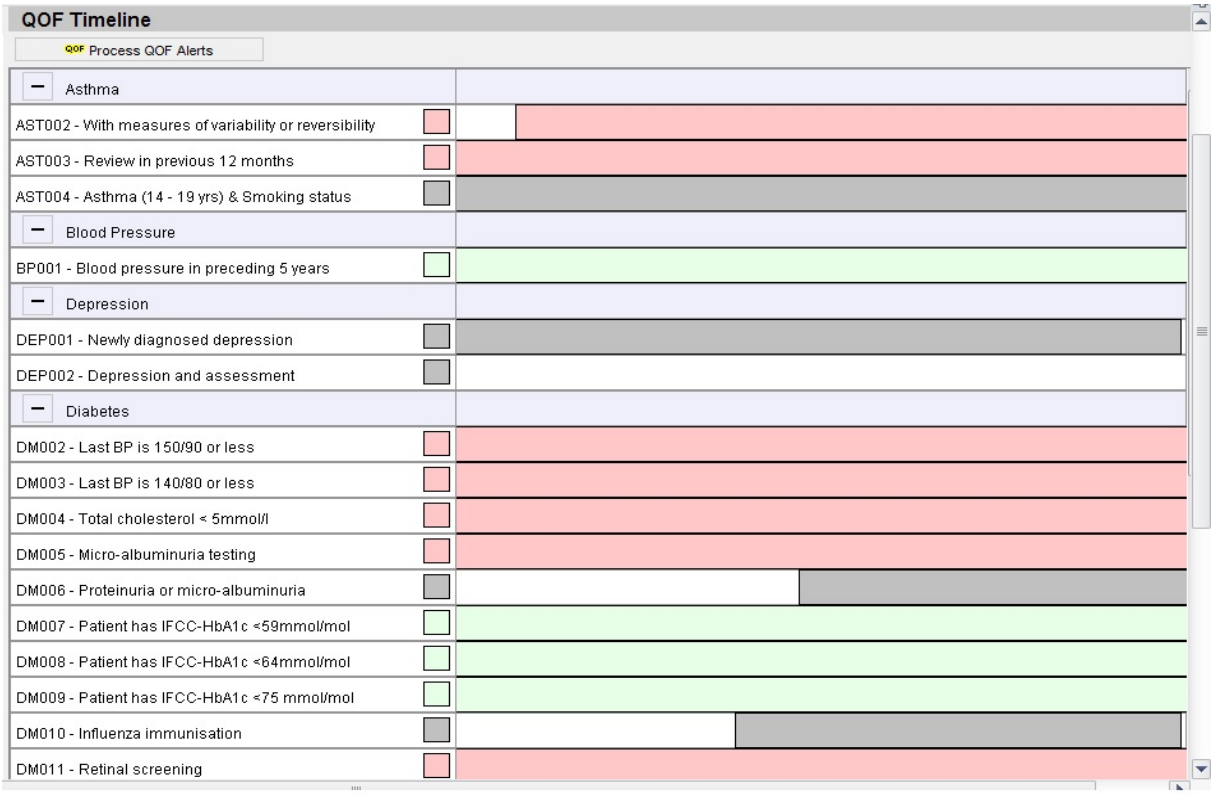


Figure 7.8. QOF timeline illustrating four exempted indicators in grey: asthma, newly diagnosed depression, proteinuria or micro-albuminuria, and influenza immunisation.

The theme of exception reporting as a gamesmanship approach to QOF indicators was introduced by a general practitioner at the beginning of my second week at site 'A'. On Monday, November 2013 he invited me for a home visit before starting the afternoon clinical session. The patient was suffering from lung cancer and was being cared both by the practice

team and by a Macmillan palliative care team. It was a 10-minute drive from the GP surgery to reach the patient's home. During this time, we engaged in a spontaneous conversation around exception reporting and how it might be used to enhance the QOF's practice profile.

The GP explained to me that 'palliative care patients' are good, because QOF allows for excepting them. He then moved further on to say that QOF exception reporting is monitored, because some people can 'game the system', a process whereby 'GPs can get to targets by excepting people'. This occurs because when practices exclude somebody it takes them out from the denominator. When GPs exclude some of their patients for a particular target they are not penalised, since it is understood that the reason for not reaching that target it is not due to lack of health care support.

The GP in question gave a clear explanation on how exception reporting works. For instance, if a GP practice needs to get 80 out of 100 people for a particular target, and they have only 70 out of 100, then gamesmanship will 'change the denominator' by excepting people to bring up the ratio. In other words, if they exclude 10 people all of a sudden they will have dramatically increased their QOF-targets for a particular condition. The GP explained that the more 'unscrupulous' doctors would do this, using unjustifiable reasons to take those patients out of the denominator. For him, this approach was 'gaming'. Thus, to game QOF's rules, according to him, would be to explore exception reporting coding for the practice's 'advantage instead of using clinical criteria', or by using 'criteria that are not appropriate'. This concept was reinforced by another GP, as follows:

> ***GP5****: …There is another element of gaming, which is…excepting people…*
>
> ***AHN****: Excepting?*
>
> ***GP5:*** *And excepting them if they…to remove them…and I think again…as long as you can clinically justify it, so if people don't turn up for appointments or…they can't…they can't take insulin when it's necessary…hmm…then there are…there are ways of clinically justifying an exception…*

However, what is clinically justifiable or appropriate? This depends very much on practitioners' judgements, which may vary according to doctors' understanding and staff ethos. There is no right or wrong. For instance, I was talking to a GP and he compared different approaches to elderly people living in nursing homes, for example, to exclude elderly patients living in nursing homes from QOF, regardless of their health status. This behaviour, for him, would not be right, unless the patients had severe dementia or were

terminally ill. As he said, it would be wrong to except 'relatively well, but disabled patients' from the QOF heart disease indicator in terms of cholesterol level (as in the case of a 70 year old patient living in a residential home with multiple sclerosis (MS) with cholesterol of 5.8) just because the patient is in a nursing home. For him, this would sound clearly 'not fair, not acceptable', but at the same time, he acknowledged that there are many ways of playing with QOF rules.

I had a conversation with GPs about how QOF is monitored, since it depends on GPs to include or exclude patients from the register. One of GPs explained to me that the IT system has QOF Read codes and 'so they can look at a practice's exception ratio'. The NHS would be suspicious if somebody has a very high ratio of excepted Read codes. Equally, if a practice gets 100% QOF marks they will want to look at their exception reporting coding. As he put it 'the NHS knows' the average exception reporting coding for any particular QOF indicator. Hence, the exception rates can be compared across areas and verified if any exception coding rate for a particular practice is too high. A classic example is the case of hypertension, because many people are on four drugs, they are very elderly, and they might get dizzy. These patients can be excepted by stating that they are on maximum tolerated medication, as exemplified below:

> *'...And we should be able to except a lot of people now because…they've raised the threshold very high and the only way to deal with that is to except people where we're not going to push the blood pressure even higher* [referring to the QOF threshold] *because they are already on four tablets…and they are 72* [years old] *and they might have a blood pressure of 141 over 85…now…I'm not going to start that person on a fifth tablet…because of that…but they don't meet the target…and so, you might need to except that case…I probably wouldn't…I probably wouldn't bother because I would hope that she might come in in a two month time…and get a better blood pressure…so, I wouldn't bother excepting her…'* [GP5]

As a GP was explaining, they have to gauge the exception rate carefully, because it is not how many you except that matters, but the ratio. For example, if 50 people have been excepted at the end of the QOF financial year, this might 'sound really bad', as he said. However, if the practice had exceeded the threshold by 80 patients, these exceptions would have no effect on the gaming process, since even if the practice have not excluded anybody they still would have clinically met the targets.

Conversely, if the practice gets over the threshold only by two patients, and for this indicator they have 50 exceptions, this would be a quite different scenario in his understanding. This situation raises the suspicion that practice had to exclude too many people in order to get over the QOF indicator threshold. As he phrased it 'sometimes it is not how many you have excepted, but it is how clear you are when using the exception reporting'.

I challenged this nicely mathematical explanation, because in the GP training programme we had a discussion around this issue and one of the GP trainers said that as long as the practice can document and reasonably justify it, it is very hard to prove otherwise. In his understanding, what 'anybody can write down' is very hard to prove or disprove.

> ***GP5:*** *Yes, and there's no need to excepting her…beforehand when the thresholds were lower it didn't matter, because you met the targets easily…there was no need to except anybody because whether they met…whether they failed or not…we met them, but now, you could argue that gaming…is increasing your exception rate…but <u>we have to</u>…increase the exception rate because <u>we have to</u> clinically defend why they are not meeting the targets…I have lots of diabetics that do not meet the target of 59* [mmol/mol or less in the preceding 12 months] *on their haemoglobin A1c…now…before I would not except them, because we always met the targets anyway…but now the threshold is a lot higher…*
>
> ***AHN:*** *So…so, there's a scope for practices and GPs to gauge how many they will except according to…how tough becomes the target…*
>
> ***GP5:*** *Yes, yes, because if it becomes, well…it's only because we didn't do it beforehand because there was no need, and exception rates were low…because it wasn't clinically relevant…because the only reason for excepting somebody was if they didn't meet a target, but we didn't need to because as a practice…we, as practice…we met the targets…that person might not have met the target, OK, but the whole practice… we met the target, so…you know, now we are excepting because one is clinically irrelevant, but two <u>we have to</u> because otherwise it looks like we're not doing very well…*

This last phrase highlights that another driver to gamesmanship is the fact that pay-for-performance is linked to the notion of quality. Thus, GP's comment '*we have to because otherwise it looks like we're not doing very well…'* reflects a concern with regard to the practice's community and peer reputation, which they 'have to' defend. As Kordowicz and

Ashworth (2011, p. 86) point out, gaming can be 'motivated by an attempt to avoid stigma' of being ranked as a low scoring practice.

Two quantitative studies (Doran et al. 2008; Gravelle et al., 2008) and one qualitative study (Campbell et al., 2011) have specifically addressed the potential for using exception reporting for GPs' economic advantage. Doran et al. (2008, p. 282) suggest that the average exception reporting is 5.3%, estimating that this strategy counted for 1.5% of the overall scheme cost (£17.2 million in 2005–2006). They concluded that GPs were not using it extensively. However, Gravelle et al. (2008, p. i) showed that, compared to the previous QOF year, low achiever practices have used exception reporting for economic advantages in up to '10.9% of the overall number of patients'. From the qualitative point of view Campbell et al. (2008, p. 183) concluded that 'exception reporting is seen by most GPs and practice staff as an important and defensible safeguard against inappropriate treatment or over-treatment of patients. However, a minority of practitioners also saw it as a gaming mechanism'.

The 2013/14 QOF contract increased the threshold of various clinical targets, as complained by health staff, but exception reporting remained stable at 4.1% of the prior year (HSCIC, 2013). Staff at both practices intimated to me that the hypertension group would have their exception reporting going up, as mentioned by the above GP. In 2012/13 the exception reporting in hypertension was 2.8% (HSCIC, 2013) and this number rose to 4.9% (HSCIC, 2014b). This might suggest that Campbell et al. (2008) have found a blend of patients' safeguard and 'gaming' strategies. Nevertheless, another mechanism might play a part in QOF data production that goes beyond the traditional understanding of 'gaming' as 'exception reporting'. This issue is code amendment. This is briefly presented here and better exemplified in Chapter Eight.

Amending QOF codes

Amending codes has become an integral part of QOF's 'quality' data production. This behaviour is an attempt to adapt reality to QOF's artificial frame by checking for coding 'anomalies' and areas that can generate practices' income, as expressed by a GP:

> '*Why would* [a GP] *sit and go through…people's* [records] *retrospectively and code things and change things…if…there wasn't a financial reward he wouldn't do it…and it's a game, because you're just coding it…coding it…you might have done everything, but is coding it…((coughing))…those sort of flags for QOF'.* [GP8]

The above GP highlights the game nature of QOF as matter of 'coding things' and indicates how vital this activity has become for practices' income. Moreover, as previously stated by a managerial staff (p. 176), dealing with coding issues is one of the most common sources of gamesmanship. I spent part of an afternoon session with the re-coder GP going over diabetic patients' records to amend some of the missing targets. This conversation illustrates how amending QOF indicators became an integral part of GPs' duty.

> ***GP7:*** *(.hh) So, let's have a look and see which of these patients we can…(hh)…I can work out…so…this gentleman…*[clicking on patient's records]*...just going to look at…diabetes…so, he saw a nurse in* [month X]*…and then he saw me and he was stable…and then I've…spoken to him…in* [month X] *as well…so, I'm sure I'd have discussed at least once about his diet…*
>
> ***AHN:*** *Yeah…*
>
> ***GP7:*** [Looking on the patient's record] *I have put "diet good"…*
>
> ***AHN:*** *Yeah, "diet good"* [confirming the information on patient's record]…
>
> ***GP7:*** *So,* [DD] *of* [MM] *I'm going to say that he had dietary advice* [typing and amending].
>
> ***AHN:*** *So, the system allows amendments…as…as retrospectively you can go and see what was missed…*[what] *was done but was not coded properly…you can…link that activity on the past and…properly code it…*
>
> ***GP7:*** *Yes, if you have enough information to say, honestly, that you've done it…*
>
> ***AHN:*** *OK.*

As can be seen in the conversation above, as long as any 'evidence' related to the indicator requirement is documented, practices can backdate the QOF Read code entry. In this particular case, the same GP had been treating the patient, therefore amending QOF codes might not sound so bad. However, someone else could have typed the information 'diet good', i.e. the diet review was performed by another health professional. Similarly, this would allow the GP to amend the diet advice QOF indicator. But 'honestly', how could one assess the quality of dietary advice given? Hence, coupled by a great scope for amending QOF data, the quality of care can hardly be assessed. The GP continued to explain that not all QOF indicators allow code amendments:

GP7: *Hmm…but some things actually have to be done at the time of diagnosis, like if you diagnose someone with depression…you've got to do the biopsychosocial assessment* [BPA] *at* [time of] *diagnosis…because if you don't enter it on that day, then you've missed that point…*

AHN: *OK, and also the patient…the patient has to return…*

GP7: *Yes, for that one you get more point…points…they got to return and have a review within a certain time period.*

Despite the tight framework explained by the above GP in regard to depression indicators, GPs can go backwards and amend it, as exemplified in the following dialogue:

AHN: *The last one question is…in your opinion, what are the most common types of gaming that GPs, or the practice as a whole, might apply to get the points?*

GP5: *OK, going back into* [patients'] *notes…hmm, when you are fixing peoples' notes because partners have not coded things…you can only do so much…when our locums don't use…don't use a BPA code, when they diagnose depression, but they would do everything from family history to past history of depression and A&D* [alcohol and drug] *use… hmm…their job, their family…and it's quite clear that they have done a BPA, and if that is documented well I can put a BPA code for them, because the BPA has to be dated for that day…*

A relevant piece in the jigsaw puzzle of data make up is coding amendments by going back into patients' notes. One of the biggest changes observed in exception reporting was in depression indicators. In 2012/13 depression exception reporting was 5.3% jumping to 20.7% in 2013/14 (HSCIC, 2014b). However, this number should be seeing as artificially produced by a combination of carefully amending strategies and exception reporting.

CONCLUSION

This chapter discussed the gamesmanship behaviour as part of the QOF framework. Gamesmanship goes beyond researchers' previous concerns about using exception reporting as a 'gaming' strategy for practices' monetary gain. It includes behavioural changes and other strategies that practices have to implement in order to make QOF work to guarantee their

income. This has been exemplified in the case of phone calls and consultation, whether to Read code the information or not, exception reporting, and amending the QOF code.

The QOF scheme diverts practice team attention towards getting the QOF points as they reach the end of the financial year. This consumes considerable amounts of time and effort by the practice members of staff. It highlights the perverse nature of pay-for-performance by stimulating what is a knavery strategy, one which might not be healthy for the public good (Le Grand, 1997). As Heath (2010, p. 93) has emphasised:

> Contemporary healthcare systems, perhaps themselves increasingly subservient to multinational commercial interests, have a worrying tendency to treat both patients and doctors as the means to some other greater purpose and neglect to treat them, at the same time, as ends in themselves. The greater purpose might be something very worthy, such as a cure, or a longer life or something rather vaguer like "the public health" or "the public interest" but, however, worthy the end, turning humanity into simply the means to achieve it, is to undermine what it is to be human in a very fundamental way and this holds even if those who are used as the means stand to benefit directly.

This link between multinational commercial interest and self-interest of those who 'benefit directly' from the QOF scheme at different levels will be further discussed in Chapter Eight, where I take depression indicators as a case study of all the QOF components operating together.

Chapter Eight

QOF DEPRESSION INDICATORS: A CASE STUDY

This chapter uses the QOF depression indicators as case study to show the way general practice has changed as result of the introduction of QOF's monetary incentive. The approach chosen is informed by Gilles Bibeau's (1988) 'tridimensional' analysis model. The attempt is to integrate the macro, meso and micro social, political, economic and cultural factors by looking at nodes of interconnectedness. By using the QOF depression indicators as 'mediating categories' the aim is to make 'explicit the intermediate steps to be followed in progressing from external forces to particular sociocultural organisations and their usage by individuals' (Bibeau, 1988, p. 410). As Gilles Bibeau argues, medical anthropologists should 'try to explain their conception of the links and articulations that connect the macro-social context and the cultural codes and how such codes are used by concrete individuals' (*ibid*, p. 410).

This chapter starts by situating the context for introducing QOF indicators for depression and their consequent transformation over the years. This process puts into perspective some of the political, economic and scientific forces revolving this clinical target, i.e. its 'macro-social context'. Then, it moves to the concreteness of daily practice. First, it situates how the practice team (the local institutional context) deals with some of the debris produced by the QOF scheme: the 'missing patients'. Second, it captures the nature of their decision on how to deal with QOF's depression 'debris' by triangulating with some of the practice meeting attendees. Third, through 'participant' observation activity with a re-coder GP, it describes the actualisation of the practice meeting decision. Shading the steps taken helps to contextualise better the action of general practices within the process by which they operate. This naturally leads to the conclusion that GPs' idiosyncratic behaviour (which circumvent QOF's normative structure) is part and parcel of a deeper and bigger political and socioeconomic agenda epitomised by QOF depression indicators trajectory.

Macro-context forces: QOF depression indicators' evolution

As discussed in Chapter Two, one of the characteristics of QOF refers to its mutability. For instance, the original 2004 GMS contract underwent a major amendment in 2006/07 resulting

in the increase of QOF clinical domain indicators from 11 to 19 clinical areas (BMA & NHS Employers, 2006). Amongst the new QOF indicators were two depression indicators comprising 33 QOF points in total. These new QOF indicators were based on NICE depression clinical guideline 23 (published in December 2004). Table 8.1 describes the depression indicators of the 2006/07 GMS contract.

Table 8.1. QOF depression indicators 2006/07: diagnosis and initial management.

Depression indicators on QOF	GMS contract year	Range	Points
DEP 1: The percentage of patients on the diabetes register and/or the CHD register for whom case finding for depression *has been undertaken on one occasion during the previous 15 months using two standard screening questions* [emphasis added].	2006/07	40–90%	8
DEP 2: In those patients with a new diagnosis of depression, recorded between the proceeding 1st April to 31st March, *the percentage of patients who have had an assessment of severity at the outset of treatment using an assessment tool validated for use in primary care* [emphasis added].	2006/07	40–90%	25

Source: BMA & NHS Employers, 2006, p. 139.

These two indicators have different functions. DEP 1 seeks to screen or search for depressive patients amongst those receiving care for chronic conditions such as in diabetes (DM) and coronary heart disease (CHD). The Patient Health Questionnaire-2 (PHQ-2) is a screening tool based on two standard questions: (1) During the last month, have you often been bothered by feeling down, depressed or hopeless? (2) During the last month, have you often been bothered by having little interest or pleasure in doing things?" An affirmative answer to either question would be considered a positive test requiring a full assessment by a qualified health professional (BMA & NHS Employers, 2006). The NICE strength of recommendation for screening depression in DM and CHD patients was "C": 'obtained from expert committee reports or opinions and/or clinical experiences of respected authorities'. This policy was not underpinned by strong evidence, since the UK National Screening Committee (NSC) recommended neither population nor opportunistic depression screening (Toop, 2011). In addition, the Cochrane systematic review addressing screening depression concluded that 'routinely administered case finding/screening questionnaires for depression have minimal

impact on the detection, management or outcome of depression by clinicians' (Gilbody, House, & Sheldon, 2005, p. 2).

The DEP 2 requires clinicians to adopt a formal tool to assess the severity of depression. In other words, apart from diagnosing depression, the use of formal severity-assessment questionnaire (SAQ) to gauge its severity became compulsory. The QOF rules allowed for the adoption of one of the following three questionnaires: the Patient Health Questionnaire (PHQ-9), the Hospital Anxiety and Depression Scale (HADS), and the Beck Depression Inventory Second Edition (BDI-II). The rationale for introducing these SAQs was that 'GP global assessment of severity does not accord closely with more structured assessment of symptoms', which according to QOF policy was 'essential to decide on appropriate interventions and improve the quality of care' (BMA & NHS Employers, 2006, p. 141). Thus, the objective of a more structured SAQ was to specifically enhance antidepressants' prescription criteria for those patients classified as having moderate to severe depression (Kendrick et al., 2009). However, the 2006/07 GMS contract guidance warns that clinicians should not rely solely on questionnaires and should take into account patients' family context and associated comorbidities. For instance, not all SAQs have been validated 'in terms of their cultural sensitivity and it is important to bear this in mind if using them with black and minority ethnic populations' (BMA & NHS Employers, 2006, p. 141). This produces a conundrum, since the use of these mandated SAQs still requires GPs to be flexible by individualising and contextualising each case. It shows the contradiction embedded in the same document concerning the use of SAQs, since general practice characteristically deals with undifferentiated cases in a culturally diverse environment (Gillies, Mercer, Lyon, Scott, & Watt, 2009). In other words, the exception might become the rule.

Additionally, the main study that gives support for adopting SAQs for depression made use of different SAQ, the 17-item Hamilton Rating Scale for Depression (HRSD-17), which was not included in QOF scheme (Cameron et al., 2011). The decision for embracing a SAQ into the QOF depression indicator was informed to a certain extent by Kendrick, King, Albertella and Smith (2005)'s observational study of GPs' treatment decisions for patients with depression *(ibid)*. Kendrick et al. (2005, p. 280) concluded that GPs 'do not accurately identify which patients are likely to benefit from treatment' and suggested that a better way of assessing depression severity was needed. Kendrick had been supported in his research by Pfizer, Lilly, Wyeth and Lundbeck pharmaceuticals, and took part as a member of 'the expert

advisory group on the mental health indicators for the 2005 Quality and Outcomes Framework' (Kendrick, 2006, p. 797). This illustrates the existing entanglement involved in the introduction of depression indicators criteria, research on depression and the psychotropic pharmaceutical industry.

Further assessment

In the 2009/10 GMS contract the depression indicators have been amended, keeping (DEP1 and DEP2) from previous years, but adding the DEP3 as a new indicator (Table 8.2). The rationale for that was to increase patients' compliance to treatment, and reducing a trend in early treatment cessation (BMA & NHS Employers, 2009). Moreover, the number of QOF points allocated to depression indicators increased from 33 to a total of 53, making these QOF indicators economically important. This new depression target stated that depressive patients should be seen and reassessed for the severity of their symptoms between 5-12 weeks after diagnose of depression.

Table 8.2. QOF depression indicators 2009/10: DEP 3 – review in 5-12 weeks.

Depression indicator on QOF	GMS contract year	Range	Points
DEP 3. In those patients with a new diagnosis of depression and assessment of severity recorded between the preceding 1st April to 31st March, *the percentage of patients who have had a further assessment of severity 5-12 weeks (inclusive) after the initial recording of the assessment of severity* [emphasis added]. Both assessments should be completed using an assessment tool validated for use in primary care.	2009/10	40-90%	20*

***** DEP 1 + DEP2 = 33 + 20 (DEP3) = 53 QOF points**.** Source: BMA & NHS Employers, 2009, p. 16.

Remarkably, the 'evidence-base' on which DEP3 was introduced was changing fast, during which various inconsistencies between SAQs were revealed. In 2009, the BMJ published two research papers addressing the QOF depression indicators. These studies were 'funded by an unrestricted educational grant from Lilly, Lundbeck, Servier, and Wyeth pharmaceuticals' (Dowrick et al., 2009, p. 6; Kendrick et al., 2009, p. 8).

The first article is a qualitative interview-based study comprising of 34 general practitioners and 24 patients. This study sought to understand patients' and doctors'

perceptions of the use of depression severity questionnaires. The authors found three consequences with the introduction of QOF depression indicators: firstly, GPs relied more on practical knowledge and clinical judgment to make a depression diagnosis than on a standard SAQ. Secondly, patients understood the use of a standardised questionnaire as an objective assessment meaning that GPs were taking their case more seriously. Finally, few patients and some doctors recognised the potential for data manipulation.

The type of data manipulation referred by GPs was the use of surrogate labels such as 'low mood or stress related problem' to avoid the QOF chore of completing the SAQ. Patients might 'game' the PHQ-9 to avoid being stigmatised as depressive patients, but two patients felt that the monetary incentive might conflict with their best interest (Dowrick et al., 2009).

The second study explored the correlation between severity of questionnaire scales and depression management. This study shows that consistency between the use of antidepressant medication and referrals when patients' scores were high (moderate to severe depression). However, severity thresholds classifying people as 'moderate to severely depressed' and hence appropriate candidates for intervention varied consistently between the two most used SAQs, the PHQ-9 (83.5%) and the HADS (55.6%) (Kendrick et al., 2009). This is a huge variation in scores between SAQs despite both having been adopted to give a 'standardised', 'objective' and 'more accurate' severity assessment of depressive cases.

In 2009 NICE updated its depression guideline. This clinical guideline 90 introduced a step-wise approach suggesting health professionals should start with the least intrusive, most effective intervention and escalating only if things did not resolve. The NICE clinical guideline still considered depression screening via PHQ-2, but mainly among those patients with a history of depression or with a chronic medical condition; however it does not mention the use of SAQs (NICE, 2009).

Linking SAQs with time of depression diagnosis

In the subsequent years, depression indicators would undergo important changes. The 2011/12 GMS contract kept the screening indicator, although the value of DEP1 was reduced from eight to six QOF points. DEP2 and DEP3 were replaced by DEP4 and DEP5, whereas QOF points for all three indicators together were reduced from 53 to 31.

With the introduction of DEP4, GPs were required to code SAQs' result at the same time as a depression diagnosis was made. This change was a further attempt to make this

indicator even more structured and rigid, probably an attempt to reduce the scope for manipulative behaviour. This process shows a direct interference in doctors' autonomy in dealing with depressive cases and the increasing difficulties facing GPs attempting to hit these targets.

Additionally, it seems to be a response to Dowrick et al. (2009)'s research, which found GPs to be loosely applying the SAQ and the perceptions of patients, who generally saw the use of SAQs in a positive light. Certainly, the bureaucratisation and intrusiveness of depression indicators have affected the GPs working process. Table 8.3 presents the changes in QOF depression indicators.

Table 8.3. QOF depression indicators 2011/12: DEP4 and 5 – coding PHQ-9 at the time of diagnosis.

Depression indicators on QOF	GMS contract year	Range	Points
DEP4. In those patients with a new diagnosis of depression recorded between the preceding 1st April to 31st March, *the percentage of patients who have had an assessment of severity at the time of diagnosis* [emphasis added] using an assessment tool validated for use in primary care. NICE menu ID: NM10	2011/12	40-90%	17
DEP5. In those patients with a new diagnosis of depression and assessment of severity recorded between the preceding 1st April to 31st March, the percentage of patients who have had a further assessment of *severity 4 - 12 weeks (inclusive) after the initial recording of the assessment of severity* [emphasis added]. Both assessments should be completed using an assessment tool validated for use in primary care. NICE menu ID: NM11	2011/12	40-80%	8

Source: BMA & NHS Employers, 2011, p. 20.

Since the introduction of QOF depression indicators, new publications started to champion the utility of QOF endorsed depression SAQs. In British Journal of General Practice, Cameron et al. (2011) studied the accuracy of QOF authorised SAQs and confirmed that HADS tended to underestimate the patients' symptom severity, whereas PHQ-9 tended to classify more patients as severe. This research further highlights the variability in using SAQs, undermining the rational quality ideal that had underpinned its adoption in 2006.

Moreover, Cameron et al., (2011)'s study showed that GPs' practical knowledge and clinical judgement based on global assessment can be considered as valid as any SAQs.

Mitchell et al. (2011) conducted a qualitative study exploring the 'impact of the QOF and the NICE guideline in the diagnosis and management of depression'. This study had a total of 38 participants (21 physicians, 13 nurses, three primary care mental health workers and one manager), organised in four focus groups. According to their findings, one of the main drivers for GPs doing the PHQ-9 was the threat of losing the QOF points, as summarised in one of GPs comment: -'To get the QOF thing you have to do it'. (*ibid*, 2011, p. e282). This study found two interconnected issues. Firstly, QOF depression indicator requirements (SAQs) were regarded as mechanistic, intrusive, and for nurses the PHQ-2 was seen as a barrier when caring for patients with chronic disease. Secondly, it induced idiosyncratic behaviour either by not labelling patients' as depression or by applying the PHQ-9 in a range of different styles, such as by asking patients to complete the SAQs on their own, recalling questions from memory to reduce intrusion, or even doing the questionnaire over the phone. For Mitchell et al. (2011, p. e284) these findings cast doubt on 'credibility, reliability, and clinical utility in routine practice, as incentivised by the QOF'.

In fact, with QOF depression indicators, GPs have to struggle to accommodate two different approaches to consultation, which Leydon et al. (2011, p. 121) have described as a 'tension' between a hard technology (SAQs) and a soft technology (a patient-centred consultation style). The QOF depression indicators embody the unsettled historical battle over GPs' autonomy, which government has always aspired to control (Lewis, 1998).

Burton, Simpson and Anderson (2013), online first in 2012, studied the effect of systematic screening for depression in the QOF era. In 2007, 90% of Scottish patients with chronic disease in primary care were eligible for screening. Although the outcome of depression screening was significant, the actual increase in the number of new cases diagnosed and treated in the four weeks' follow up was small. The authors suggested that policy-makers should re-consider the validity of this strategy in primary care (Burton et al., 2013).

Biopsychosocial assessment

In the 2013/14 GMS contract, QOF depression indicators underwent another important change, but the number of points allocated remained the same: 31 QOF points. The first change was the end of PHQ-2 as a screening tool for depression amongst those being treated

for chronic conditions. The second change was a major one: the elimination of SAQs from the indicator. However, a template was introduced to guide doctors in the exploration of their patients' biopsychosocial dimensions. This biopsychosocial assessment (BPA) should be Read coded at the same time as the diagnosis. Finally, a minor change required reviewing patients between ten days and 35 days of the initial diagnosis of depression. These changes, to a certain extent, might have been a result of the research battle between different groups. For instance, Cameron et al. (2011, p. e425) sent a clear message in this regard: 'there is a danger that the setting of the QOF standard examined here has lent an unjustified veneer of confidence to the management of the condition, obscuring the paucity of basic research'. This polite remark reinforces the point that the criteria for QOF depression indicators are not predicated on evidence-based medicine.

Nevertheless, despite the changes to the 2013/14 GMS contract, offering a more open and 'holistic' approach to depression diagnosis, the requirement that the biopsychosocial assessment be recorded at the time of diagnosis of depression, maintained a strong hold on doctors' autonomy. This would have important consequences on daily life of general practice as it maintained the bureaucratic structure of the previous indicators. Table 8.4 summarises the 2013/14 depression indicators requirements.

Table 8.4. QOF depression indicators 2013/14: the biopsychosocial assessment.

Depression indicators on QOF	GMS contract year	Range	Points
DEP001. The percentage of patients aged 18 or over with a new diagnosis of depression in the preceding 1st April to 31st March, *who have had a biopsychosocial assessment [BPA] by the point of diagnosis* [emphasis added]. The completion of the assessment is to be recorded on the same day as the diagnosis is recorded. NICE 2012 menu ID: NM49	2013/14	50–90%	21
DEP002. The percentage of patients aged 18 or over with a new diagnosis of depression in the preceding 1st April to 31st March, who have been *reviewed not earlier than 10 days after and not later than 35 days after the date of diagnosis* [emphasis added]. NICE 2012 menu ID: NM50		45–80%	10

Source: BMA, NHS Employers, & NHS Commissioning Board, 2013, pp. 17-18.

No clinical assessment tool

In the 2014/15 QOF depression indicators were again dramatically modified. All formal evaluation tools have been removed, remaining just the need to reassess the patients between ten to 56 days. The QOF points' allocation for depression dropped to ten points. Table 8.5 shows what remained of QOF depression indicators.

Table 8.5. QOF depression indicators 2014/15: no formal assessment tool.

Depression indicator on QOF	GMS contract year	Range	Points
DEP003. The percentage of patients aged 18 or over with a new diagnosis of depression in the preceding 1st April to 31st March, *who have been reviewed not earlier than 10 days after and not later than 56 days after the date of diagnosis* [emphasis added]. Based on NICE 2012 menu ID: NM50	2014/15	45-80%	10

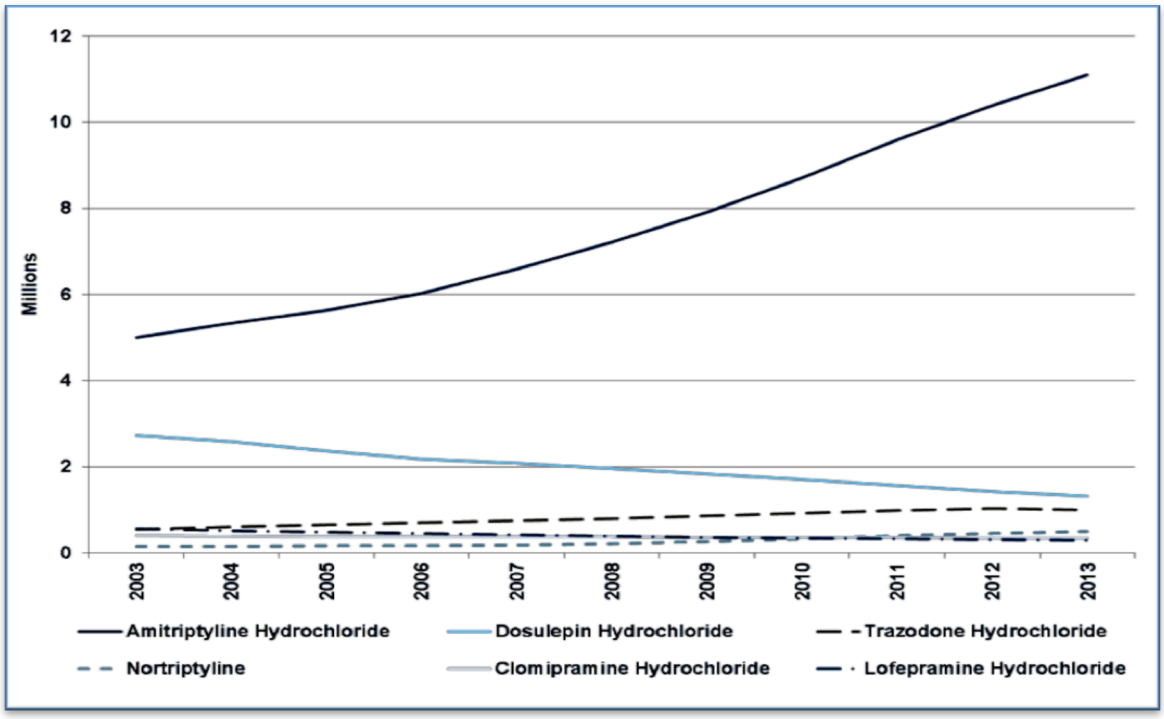
Source: BMA, NHS Employers, & NHS England, 2014, p. 86.

Thus, the trajectory of QOF depression indicators from 2006/07 to 2014/15 GMS contracts has fluctuated in terms of its criteria, number of indicators, points allocated, range of achievement, and the level of constraint upon GPs' autonomy. Despite Lester et al. (2013)'s study that GPs had a sense of pride with the fact that QOF represents an evidence-based model of practice, the QOF depression indicators show otherwise. The rationale for introducing QOF depression indicators was based on a consensus of experts, some of them with strong bonds with the pharmaceutical industry. These QOF indicators emphasise that EBM is more an approach to authority and power rather than any rigorous methodological use of the available scientific information (cf. Lambert et al., 2006).

This period of QOF depression indicators adoption suggests that it has induced a medicalisation process in people presenting with mood problems. A recent interrupted time series study shows that 'incentivised case finding perpetuated the rise in antidepressant prescribing because of a perceived need for clinical action over and above referral for counselling or watchful waiting' (McLintock, 2014, p. 7). Even after the retirement of the PHQ-2 as a screening tool in QOF depression indicators, the tendency in practices is to maintain these two screening questions despite the lack of good evidence of their benefit (Alderson et al., 2014).

The introduction of QOF depression indicators has been blamed for a 60% increase in antidepressant drugs prescription in the UK (Spence, 2013). For instance, the expenditure on

screening for depression in CHD and diabetic patients in the 2012/13 QOF contract year accounted 'for £6 million per annum in the context of the £1 billion total estimated cost of QOF each year' (McLintock et al., 2014, p. 7). This suggests the strong connection forged between the state and biocapital. Graph 8.1 shows fast increase in citalopram use from 2005 to 2011. Sertraline presented a steady increase in use from 2009 to 2011 and then it soared until 2013. These drugs known as selective serotonin re-uptake inhibitors are mainly used for treatment of depressive patients.



Graph 8.1. Selective Serotonin Re-Uptake Inhibitors (SSRI), by items dispensed. The trend shows that the use of citalopram has increased over the period but the rate of growth is now declining; sertraline has seen increasing use over recent years. Source: National Statistics and HSCIC, 2014.

Thus, it is plausible to state that QOF has worked as an inductive device boosting the market of antidepressant drugs and fulfilling the current role of the government: the market animator (Rose, 2006).

AN ETHNOGRAPHIC STUDY OF 2013/14 QOF DEPRESSION INDICATORS

As previously discussed, in the 2013/14 contract SAQs were replaced by biopsychosocial assessment (BPA) for newly diagnosed patients. However, the timeframe of doing it remained tight, stating that the BPA needed to be done on the same time as the diagnosis

entry of depression. Moreover, for the practice to get its full quota of QOF points for depression, patients needed to be re-assessed between ten to 35 days counting from the diagnostic entry date. From a GP's point of view this might just bureaucratise the care than have clinical meaning:

> *'…And it's the same for depression reviews, somebody might come in for a depression review on day 36…now, you have to come in between day 10 and 35…and just happened that you made his appointment too late…and this is a…this is a farcical side of the QOF: why is he coming on the day 36?…Why is that bad? Why should we be penalised for that? But I can't alter that date; I can't pretend that he came in…the day earlier; I can only…I can only do…so…the chances are…that person didn't code depression review, I can only put in depression review…if they actually came within that time frame…so gaming is…I feel that gaming is exaggerating or amending…dates and clinical work when it didn't really happen…'* [GP5]

The consequence of this framework is translated by the QOF timeline as a short red horizontal bar, which informs the practice team that they missed that target or that it needs amendment (Figure 8.1).

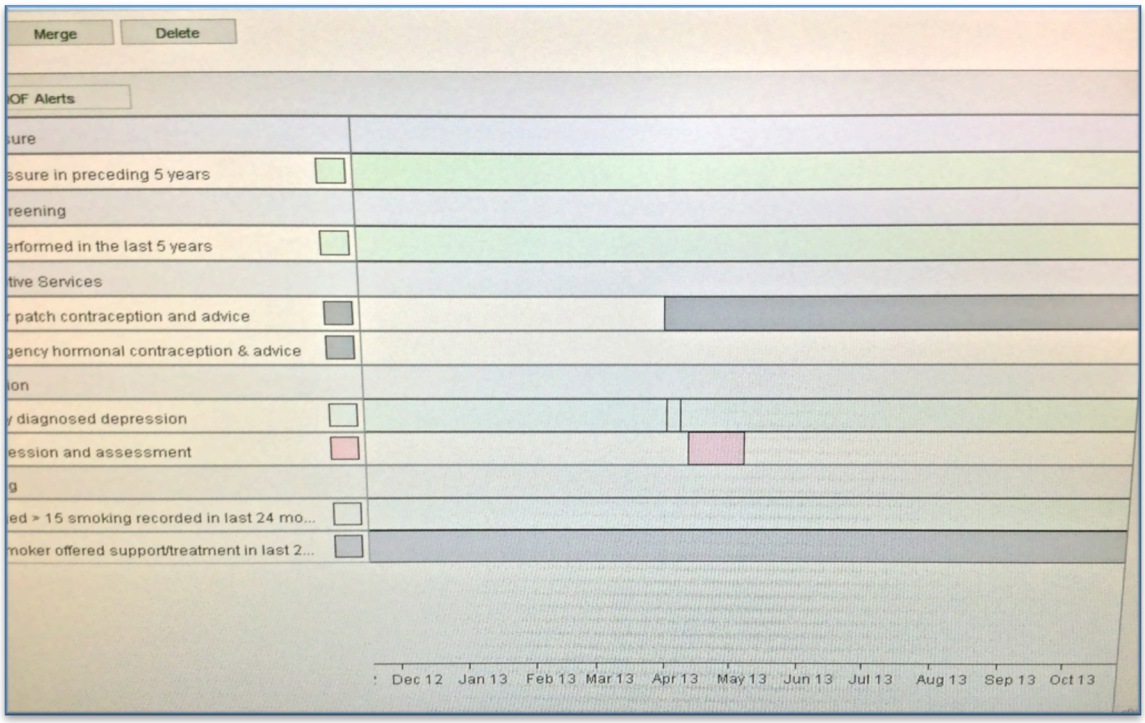


Figure 8.1. Computer screen snapshot showing the depression review indicator as a small red box on QOF timeline.

The problem GPs face in trying to fit reality within QOF rules is understandable. To do a 10-minute consultation plus QOF coding requirements, pressured by the dynamic of daily work, such as when a GP session is running late, might be a challenge for some GPs. Therefore, finding alternatives such as 'depressive mood' to avoid the consequences of coding properly and having to go through a full template might be a reasonable escape route. This behaviour has also been reported elsewhere (Mitchell et al., 2011; Lester et al., 2013).

Most of the researches on QOF do not mention the role played by non-collaborative GPs or locums in 'messing up' the QOF codes. This makes amending codes an intrinsic part of QOF gamesmanship, as quoted below:

> *'...If* [my colleague] *sees a patient and he just puts low mood depressed and he won't put the BPA code in…and I can't put that in for him, because there's no clear evidence that he has done a full history…so if you're gaming…you're just put it in* [referring to a BPA code]*…hmm…to avoid gaming you have to be realistic…you have to be able to defend why I - in an administrative role - determined that BPA was done and I would have to be able to say that to…somebody from a QOF team* [inspectors]*…I can say that was a BPA* [referring to amending a well-documented locum consultation]*, but I can't do it* [for my colleague], *I can't…I can't look at his notes and say that was BPA…'* [GP5]

The underlying message in the above dialogue indicates that not all GP colleagues were taking seriously some of the QOF indicators. Locums, who are not incentivised by QOF, but cover many of GPs' hours, exhibit the same behaviour as exemplified by the following dialogue:

> ***GP11:*** *The thing is…a lot of hours is done by…hmm…locums…so in the way that you start talking about gaming…we won't put a code of depression in until we have it done* [BPA]*…so, then, again, the diagnosis is delayed […] say, if you're seeing them today…and then you don't go to the whole of your biopsychosocial assessment…see, then the next day or the next appointment or the third appointment then you put the full of biopsychosocial assessment on…so, once you've done it in two or three appointments, then you put the code in and then you put the biopsychosocial assessment coding…so, you know, as opposed to put the diagnosis when you first see them, when they've been diagnosed as depression…*
>
> ***AHN:*** *This you are saying is a kind of gaming…*

The above two quotations concern non-collaborative and locum GPs circumventing the QOF's rule compulsory nature, i.e. the requirement of BPA Read code entry at the same time of the depression diagnosis. Though, from the point of view of the QOF quality depression indicators, this behaviour makes the rationale for introducing the follow up depression indicators technically irrelevant, as the following conversation shows:

> ***GP11:*** *...If you look at the depression assessment…you are supposed to see somebody on the first assessment…and then see them within two weeks…after this…after the first assessment* [according to NICE guidelines], *but if you are coding the depression in your third or your fourth assessment…then that becomes immaterial…*
>
> ***AHN:*** *OK…hmmm…*
>
> ***GP11:*** *OK, because the danger period* [referring to safety net] *of somebody seeing some…a health care professional…about their depression is the very first few appointments, first few weeks…so, you have to see them within two weeks afterwards…OK…then…but if you are putting the coding…on first appointment and…no…on your fourth appointment…then the review becomes immaterial then…*
>
> ***AHN:*** *If you…if you postpone the coding, so…then the…the follow up…that will be in two weeks' time…*
>
> ***GP11:*** *No, but then you will probably be about four weeks' time later, because then…you'd already seen them three or four times…so probably* [the patient] *got a bit better…you know, so, that one…that…the reviewed one was supposed to be…*[seen]*…shortly after you've made your diagnosis…*
>
> ***AHN:*** *But if I start with the medication, for example, in the first* [day]*…I should… have…coded it…but I…*
>
> ***GP11:*** *You can't code it…because you haven't done the biopsychosocial assessment!*
>
> ***AHN:*** *OK…((slightly laughing))* [as capturing what the GP was trying to convey].
>
> ***GP11:****…because the two have to be put in at the same time: the 'diagnosis of depression' and the 'code for…biopsychosocial assessment'… have to be put in at the same time…*

The above dialogue reinforces the artificialities created by QOF, which inevitably practitioners find their way around by gaming the system, postponing the coding entry and

breaking the original safety net. Moreover, through the re-coder GP's amendment activities, this reality is conflated to give the appearance that it has been done according to the current QOF rules.

Mutability of QOF as a contextualising factor in gamesmanship

The changes in 2013/14 QOF depression indicator rules had affected health practice staff in one of the surgeries. During the previous seven years practices were acculturated to using the PHQ-9 SAQ and this systematic usage left practices with an ambivalent notion about their value:

> *'PHQ-9…again…PHQ-9…I'm a little bit ambivalent about that…you bring that in, and it's a new thing, and it's a way of quantifying it, and it was done and that initial…push…it was good…hmm…it concentrates minds and I'm sure it did have an improvement in…patient care…hmm…but then you find that you're not getting remunerated because you've missed…the timescale for getting the set of PHQ-9 and that used to drive everybody "bananas"…and so, you'd get folks that…stopped using it…so, it's…it's very contradictory to what they're wanting…and I don't know what the evidence-based* [medicine] *says…for that, I suspect there is none…I mean…most of psychiatric things by their nature…don't have it…'* [GP10]

The above ambivalent feeling about the use of PHQ-9 reflects both the 'psychiatric nature of things' and the remuneration timescales built within the QOF depression indicators. The constant changes in QOF depression indicators might have contributed to this ambivalent context, as well. The fact that something totally 'out of the blue' was brought in (the BPA) to substitute the SAQs, meant another different approach when caring for depressive patients. This affected some of the practitioners, as the following dialogue explains:

> ***N2:*** *…I think…one of the biggest problems with…that particular one, with the depression one…they changed the guidance at the beginning of the last year* [2013] *and they changed the way they do it…and…as nurses we don't see a lot of depression patients anyway…we usually see them at follow up and things like that, but very rarely are we the ones who do the initial diagnosis…we do a few, but probably not as many as the doctors do…and…of course, when we've changed the guidelines…I haven't quite got my head around it all…I think you just forget if you're not reminded or if it's not put in black and white in front of you…and I think, I was one of the ones who forgooot ((long and fading))…so, obviously they changed the way they did it last year and I just…you've got so many other things to think about…*

AHN: *But there's a huge number…it's not just you…*

N2: *Oh, no…no…the problem is with this particular type of patients though, it's that…obviously…it's a biopsychosocial assessment that hasn't been ticked ((coughing)) and I think it's been the case of, because it's something that's new…it's not been embedded in your head…so, like I've said, I don't think it's just me that's forgotten, I think that lots of people have forgotten to do it, which is why the number is so high now…hmm, you can't go back retrospectively as well and try and put it in, you know…*

The fact that the number of missing patients were 'so high', has given the practice team a difficult problem to solve, as they were reaching the end of the QOF financial year. What follows is an account reflecting the practice team's decision to solve the problem in order to guarantee some QOF points and their 'quality' standards. Thus, the theme of gamesmanship needs to be placed within this context of changes, of QOF's mutable nature.

Meso-context: an institutional agreed decision

In January 2014 I arrived at the surgery for a practice meeting, which started at 8:30 a.m. I had been attending the practice meetings since my fieldwork started and the members of staff were familiar with my presence. In these meetings GPs, GP registrars, F2 doctors, nurse practitioners, pharmacists, and managers get together to discuss a variety of relevant subjects. Inevitably, QOF sometimes predominates, which was the case during this particular practice meeting, when the QOF 'depression-coding problem' was presented.

The practice seemed to have been trying to tackle the problem for some time, by attempting to re-call patients and re-assess them in order to put the right codes in. Unfortunately, this strategy had not worked out as practice team wanted and the timescale left for them was too constrained to maintain the same plan. They were quite stressed out by this situation and one GP came out with a plausible solution: '- if these missing patients were not properly diagnosed with the use of PHQ-9, one cannot be sure they were really depressed'.

To clarify his point, he compared the COPD diagnostic criteria, which require, according to QOF, the use of spirometry to properly diagnose a COPD patient. In his understanding, it would be 'OK' to recode these 'missing patients' as not having depression, since they were not objectively assessed. There was little room for an alternative, because there was otherwise a lot of work to be done in a short time period. So, collectively they agreed with the GP's proposition to exclude the missing patients from the register.

This practice decision can be characterised as gamesmanship behaviour in two ways. First, by adopting a criterion that was no longer valid according to the QOF 2013/14 contract, though medically it might have validity and support. Second, the solution they came up with, though very ingenious, lacked consistency, since it was applied only to those missing patients and not to all depressive patients who had been newly diagnosed. The fact that it was not evenly applied across all newly diagnosed depressive cases makes practice team's strategy questionable.

However, it illustrates how SAQs, once fiercely criticised both by GPs (Jeffries, 2006) and researchers (Cameron et al., 2011; Mitchell et al., 2011) for not representing a more personal and holistic approach to patients' subjective states, has become a gold standard criterion for diagnosing depression. Alderson et al. (2014) found that PHQ-9 is still being used despite all the controversy around SAQs, illustrating QOF's inductive power on general practice health teams' behaviour. Thus, this situation describes how practice staff exerted their agency against a vertically driven policy by adapting QOF rules to their own needs. More importantly, this approach illustrates that the monetary incentive was the main reason for this idiosyncratic behaviour.

After finishing the practice meeting, I was scheduled to stay in a nurse's consultation room, to observe her activity. This gave the opportunity to crosscheck the information about the practice strategy that had been developed to deal with the missing patients: the 'newly' diagnosed depression patients.

> ***AHN:*** *Dr 'GP' suggested to clear them up* [the missing patients newly diagnosed with depression]*, because they were not properly diagnosed* [by not using the PHQ-9] *in terms of…like he compared with COPD, if you don't do the…the spirometry you cannot hmm…hmm…diagnose or properly code as COPD* [patients], *so he was arguing that it would be OK to go back and*…[exclude patients from the register].
>
> ***N2:*** *But I don't agree with that!*
>
> ***AHN:*** *But I think…what* [they are planning to do]…
>
> ***N2:*** *I think you should…COPD can be very marginal to the point…you can have…you can have it shown on a X-ray but, patients can pass their spirometry yet their symptoms actually support the fact that they've got COPD, and sometimes you have to use your clinical judgement…yes, they might have spirometry missing, but does…do the symptoms and other diagnostic factors fit with this patient having COPD?*

AHN: *Yeah, but what…he was saying is that…that it would be OK for Dr 'GP' going into the records and…kind of deleting the…the…*

N2: *…the diagnosis…*

AHN: *Yeah, should be re…redone, again…in order to catch up…*

N2: *I don't agree with that…*

AHN: *Yeah, but I think that's what they're going to do…*

N2: *I don't agree with that as that…because I think it's a little bit…cheating…((muttering))…*

AHN: *Oh, yes…would they call it 'gaming'? Playing with the thing…because patients are being cared for* [anyway]…

The above dialogue shows a conflict between personal values and the practice collective agreement, which might imply that those at the top of hierarchy have influenced the decision. However, the conversation changed to the rationale behind the decision. This seems to have some consistency, since health staff were taught during the seven years that PHQ-9 was the standard to assess patients' depression severity, stated in this way:

N2: *Yeah, if patients are coming and they've got a low mood like or for example, like…saying that they haven't had a PHQ-9 done, if they haven't had a PHQ-9 can you properly…diagnose them as having a depression? And I think what they were saying is: - 'Without a PHQ-9, the patients got a low mood, because what is your point of being able to measure it?'*

AHN: *OK…*

N2: *It's very subjective, isn't it?*

AHN: *Yeah…*

N2: *And at the end of the day…a PHQ-9 actually helps support…a diagnosis that you put in…although it's still very subjective it gives you an assessment score…and that assessment score will tell you whether somebody is just mild, moderate, moderately severe, severe or whatever, you know…it gives us some sort of gauge…to measure across…*

AHN: *But it's also subjective…*

N2: *It is still subjective, but it gives you…something that is a little bit more substantial than just… your opinion…on somebody sitting there and giving you a history…you know what I mean? It's not measurable, taking a history it's not measurable, doing a PHQ-9 is measurable, does that make sense?*

AHN: *Yes, it makes sense…*

N2: *So I think, what Dr 'GP' was saying is that: - 'if it's not being measured…how can you say the patients actually…got depression?'*

AHN: *Yeah, so, and he was justifying this to just go…go into the records…delete…*

N2: *And take the diagnosis off…yeah…*

AHN: *And this will…take a lot of people...the…*[from the]*…denominator out…and this will increase or maximise the points…*

N2: *Yeah…*

The contrast present in these two previous nurse quotations is clear. The first quotation shows a disagreement with the approach adopted in the practice meeting. The second quotation narrates the rationale for using the PHQ-9, a more objective, measurable approach to patients' subjective nature. This illustrates how QOF has become a 'big game', one that distracts the practice team from clinical practice issues to one that concerns the production of necessary data to secure the practice's income. As David Loxterkamp (2013) has suggested, GPs live in a time of metrics within which pay-for-performance schemes have become a 'Frankenstein' who now masters his 'creator', requiring computers to be cared and fed accordingly.

As the fieldwork continued, in February 2014, I had the opportunity to observe a clinical session with the GP proponent of using PHQ-9 as a standard criterion against which they could justify the exclusion of newly diagnosed patients with depression who were 'missing'. At the end of the clinical session, I had an opportunity to record our conversation.

AHN: *You mentioned as well with depression* [in the practice meeting]*…hmm, that a way around the level of score would be to consider those with…hmm…who haven't had a proper assessment* [with PHQ-9]*…no…not counting as a…a* [new depressive case]…

GP13: *If…if people put a diagnosis down…without doing a PHQ-*[9] *assessment…my argument would be…that's an incorrect diagnosis because you've got no evidence…it's like putting hypothyroid down without doing their TSH* [thyroid stimulant hormone]*…so it's the same…you know…you wouldn't do all of them…therefore you could legitimately…put a different code down…*

AHN: *OK…*

GP13: *I would…you know…I would happily…to say…if you have done a PHQ-*[9] *it wasn't a question…you might've thought it might be* [depression diagnosis]*…but you're guessing.*

The above dialogue shows that an instrument such as the PHQ-9 has now been co-opted by some GPs as a standard tool for diagnosing depression, not because they believe in it, but because it can be a useful mean of justifying practice team's decision to exclude the 'missing patients'. We continued our conversation around the QOF intrusiveness, mainly when it comes to mental health:

AHN: *At the meeting* [the practice meeting with regards to QOF]*…you said…some…interesting things…I was quite…hmm…looking forward to talk to you…*

GP13: *yeah, well, sure…*

AHN: *You said, for example…hmm… -'We don't like it! Patients don't like it! So, why we have to do it?'…*

GP13: *Yes, so…some bits of QOF…hmm…particularly mental health…hmm…I don't agree with…so, for example, these bio…psycho…social assessments…they are very proscriptive…and I don't think…I want to ask them,* [I'm] *not sure the patients want me to ask them…hmm…and I do bits of it so…if I see somebody who's just, you know, depressed…and it's obviously work related…you know…I saw somebody who was…hmm…basically a bereavement counsellor, who had the workload doubled and every now and again they get a family who kicks off and gets upset and takes it out on them, when… it's nothing to do with them…they're there to help…and she's just gone off stressed…so, I'm quite happy to…you know, I know what is going on with her…I don't need to ask her about the other possible causes…because I know exactly what it is…so I see that as a waste of time…and I don't do this…and… even when I'm reminded…I don't do it…because…I just see it...it's redundant…it's not right…*

It is quite clear that QOF intrusiveness has been avoided by some GPs, as exemplified in the high number of 'missing patients' in the QOF depression indicators. Other domains of QOF have also been seen as inappropriate:

> *'...I think asking* [the patients] *about impotence in diabetes is...I wouldn't do it...I didn't 'use to do it...but I do...I suppose I do it for that...I kind of expect it to be done in the clinic setting* [referring to diabetes clinic]*...and asking that is sort of...not necessarily my role...and then there's some stuff that I just don't...agree with...and then there's a few of it...for whatever reason we will never achieve...so...we can bring people in and try to catch up...I don't think we should be using...GP appointments to do...just QOF work...I don't mind doing QOF as part of my job...but I don't think we should just do QOF things...'* [GP13]

Health professional staff unwillingness to do QOF 'stuff' (and the fact that they 'have to do it' for monetary reasons) conflicts with the daily work of general practice, accumulating QOF-tasks at the end of financial year. This becomes a problem, which needs to be fixed. As described in Chapter Seven, in the case of erectile dysfunction, a nurse had to do it over the phone, along with a number of other reviews.

These contexts show ways within which externally driven policies can have a negative effect on professional motivation and commitment to clinical care in favour of other financially motivated preoccupations (Lester, Sharp, Hobbs, & Lakhani, 2006). When professionals work in a 'regulatory activity managed in a bureaucratic fashion by people unknown to the recipients of the incentives' this trade-off mechanism is more likely to occur (Marshall & Harrison, 2005, p). Thus, the QOF scheme is a vertical policy that gives little room for professionals to discuss their views on any particular indicator.

Crosschecking information that I heard and observed in the practice meeting with those who had attended it opened the possibility for a certain level of understanding. However, this ethnographic study allowed me to observe the actual procedure of recoding the depression indicators for those newly diagnosed patients.

Micro-context: amending the QOF depression indicators

The participant observation entailed a long morning session with a re-coder general practitioner in February 2014. I arrived at the surgery at 8:30 a.m. to observe the re-coder GP. The whole session lasted four hours and 41 minutes. In order to facilitate the understanding of this activity, its content will be presented in four subtopics: (a) explaining the main

recoding activity; (b) trying to find the right balance; (c) seeking for written evidence; (d) increasing or decreasing the QOF point values.

(a) Explaining the main recoding activity: the main QOF task of this session was to recode (redefine) the newly diagnosed depression cases on the practice register. These patients had been diagnosed as depressed without simultaneously putting the BPA coding into their records. The rationale for doing this QOF task will be explained further below.

> ***AHN:*** *So…what are we going to see today?*
>
> ***GP11:*** *Depression…*
>
> ***AHN:*** *Depression…*
>
> ***GP11:*** *Yeah…what we talked about at in the…hmmmm…*
>
> ***AHN:*** *On the meeting…*
>
> ***GP11:*** *On the meeting, yeah…*
>
> ***AHN:*** *Thursday…*
>
> ***GP11:*** *So…the…*
>
> ***AHN:*** *What was agreed there?*
>
> ***GP11****: Well, what I'm going to do is to look at depression…and…take away the…hmm…the code for depression...for the ones that haven't had the…biopsychosocial assessment…and put it down on as history of depression or symptoms of depression…which is basically…what it is, but not the actual code as such…*
>
> ***AHN:*** *OK…*
> [Started typing and then we talked about unrelated subject, then the GP returned to focus on the computer and started typing again and after 5 minutes he addressed me].
>
> ***GP11:*** *Right, OK…Where are we? Depression… 'Missing patients'…we have 62 patients…*

Then, after producing a list of patients to be worked out, the GP picked a patient's record and started to look into the patient's notes. As he could not find any evidence of a BPA history having been taken according to the patients' record, we started to search for alternative codes, such as low mood:

GP11: *So, what we need to look at…depression code on* [DD/MM]*…2013…*[typing]*…it's an entry of depression code to put in…right…*[DD/MM]*…2013 that was a locum…putting depression…*[starts looking at potential substitute codes]*…depression…depressive disorder…mild depression…so what I'm going to do…mild depression…amend code…amend 'Read code'* [typing]…

AHN: *Depressed mood?* [The chosen code].

GP11: *Yeah…Let's see if there is anything else I can use…'cause symptoms of depression is the other one…symptoms of depression…or depressed mood…probably depressed mood…change that one as well as depressed mood…OK…so that should get rid of our patient…so I'm going to put a note* [that] *I have seen him…so I can check whether it has worked or not* [the GP then starts to write down the patients' NHS register number]*…see if that…you know…I'll check it out tomorrow, just to make sure…*

The above conversation reflects the collective agreement at the practice meeting, which has authorised the re-coder GP to carry on these amendments into the patients' notes. Then, throughout this morning, we ran through the list of patients seeking for evidence to: (a) put a code entry of BPA and properly code it; (b) put an entry code of ongoing depressive case, by finding evidence that, in fact, the patient was misdiagnosed as newly depressed; and (c) as a last resort, relabelling them as low mood and taking them out of the depression register. The above dialogue is an example of the latter.

(b) Trying to find the right balance: for safety reasons, GPs have to gauge correctly what changes to make when they are recoding potentially important diagnoses. If the patients have clearly a 'red flag' (in this case, suicidal risk) an alternative needs to be found. One strategy, from the point of view of QOF, is to seek for evidence on patients' records of ongoing depression (not newly diagnosed), because it is not a clear cut decision when to consider the patient with a past history of depression as having a new or ongoing episode. This may be the case when patients' baseline depressive mood state has worsened and might be 'wrongly' classified as a new episode instead of ongoing depression. Thus, searching for evidence on a patient's record of ongoing depression and recoding them as such, will maintain the patient on the depression register, while improving the practice QOF points value profile. Another strategy is to look for evidence that a secondary care mental healthcare team diagnosed the

patients with depression. This frees the practice of having to follow the QOF rules i.e. doing the BPA:

> ***GP11:*** *OK, so the added diagnosis was there…*[reading patient's record notes]*…but that really is a depression, no doubt…can't really take that one out…because that's an important one…*
>
> ***AHN:*** *Hmm…because there's risk of suicide…a suicidal risk…*[reading patients note]…
>
> ***GP11:*** *Hmm-hmm…*[yes]…
>
> ***AHN:*** *But this was previous to the…of this year, so does it influence… the…the…*
>
> ***GP11:*** *Hmm, that's a new one…because could be like the new diagnosis and he's been OK since then…*[looking at patient's note…]*…didn't go to the…didn't go to his appointments…so, I don't think I can take that one out…but then has it…depression being diagnosed…*[the GP continues to search into patients note]*…depression hasn't been diagnosed…*
>
> ***AHN:*** *But he is on…citalopram…*
>
> ***GP11:*** *But then they prescribed him anti-depressants and promazine!* [A medication that belongs to the antipsychotic drug class group]*…I'll take that as depression being diagnosed by psychiatry…*
>
> ***AHN:*** *hmm…Not here?*
>
> ***GP11:*** *Well, as well because depression being put in after he's been seen by a psychiatrist…*

In this example, searching for some 'evidence' in the patient's note that fulfils the QOF rules has become an important task for GPs. This reinforces the idea of QOF that quality might reflect, to a great extent, the way practices play the QOF game and/or stretching its rules through gamesmanship behaviour.

(c) Seeking for written evidence: another task during this morning session was to seek for written evidence as in the diabetes case illustrated in the Chapter Seven (p. 204) on amending QOF code entry. The same logic applies here: to backdate the BPA coding into the patient's record based on the information available:

GP11: [Looking at patient's record]…*almost gone through all the biopsychosocial assessment…the only thing he didn't ask is…hm…financial issues and…hmm…he talked about alcohol…so, possibly he talked about substance misuse as well…*[checking patient's note]…*OK, if you look at the biopsychosocial assessment…template* [opening the depression template and starting reading the template check list]*…symptom duration, personal history, family history; didn't look into…*[silence]…*quality of* [interpersonal] *relation…he talked about relationship, living conditions…social support…talked about his family…employment and/or financial worries; current or previous alcohol* [and substance use]*…he's looked into that…*

AHN: *Just let me take a photo of the template* [while taking a photo]*…yeah, thank you…*(Figure. 8.2).

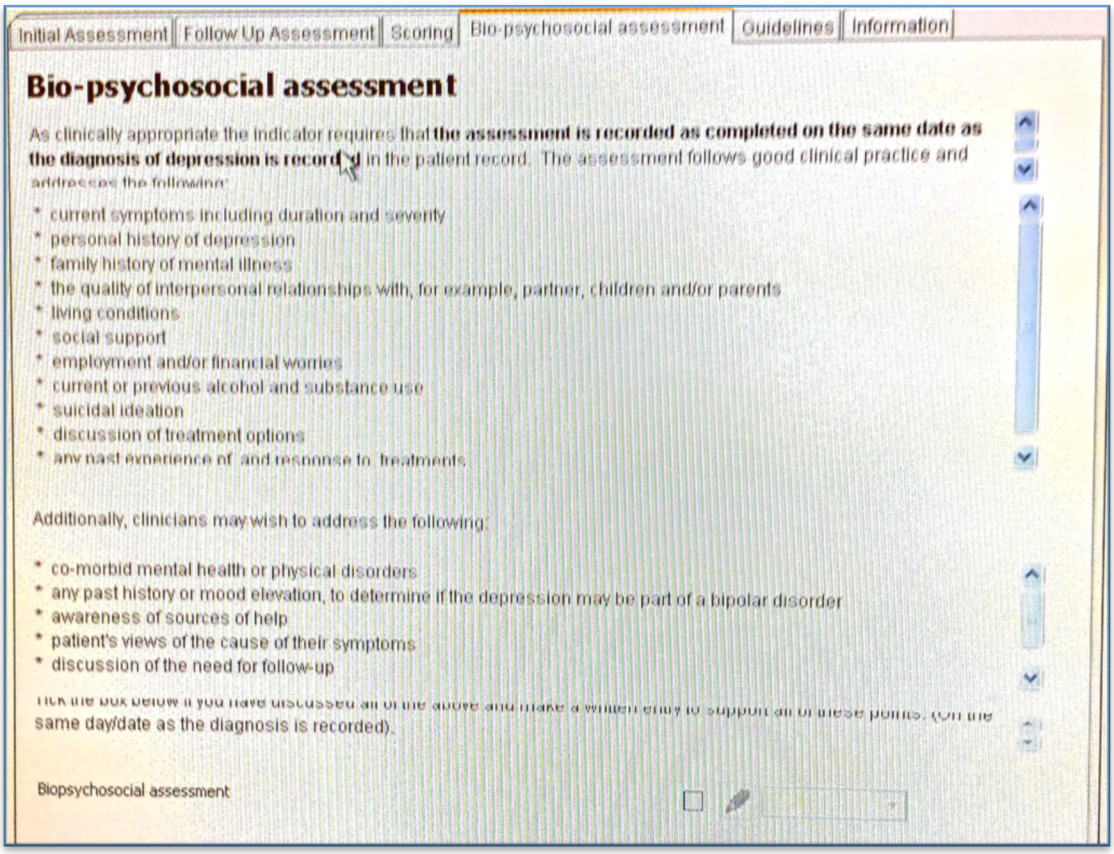


Figure 8.2. The biopsychosocial assessment template with the list of topics to explore during the consultation in order to fulfil the QOF depression indicators criteria.

GP11: *OK, so…discussion option treatment…I think he's done most of the…*

AHN: *He's done most of…*

GP11: *Almost all of* [the things]*…this file shows…the employment I didn't look into it* [meaning he could not find the evidence for that]*, but everything else is there, so I think I'm going to put the biopsychosocial assessment…*

AHN: *You just can…you can copy and…and put that information…or you can just…*

GP11: *No, I can just put the code in…OK, so, change the details, OK, putting on the* [DD/MM]*...was when we've seen him…and take it…and it was* [Dr. X]*…OK, clinically relevant…contact was 'face-to-face'...*[typing].

AHN: *Can you put…slash (/), is it OK?*

GP: *Yeah, something about System-one that you can get…what they call it an 'accelerated' Read code, because it takes…it takes you straight into it…*

Despite being a template, the biopsychosocial assessment is only a reminder of areas to cover by the GP during the consultation. The GPs do not need to tick any box, but have to write down in a drop-box the issues covered, according to a list of suggested items, to contextualise patients' depressive mood. Most doctors probably will do it through a multiple encounter due to the small amount of time available in a standard 10-minute consultation. Thus, QOF depression indicators seem to clash with the GP tradition of longitudinal care, since it establishes a deadline for doing the BPA and the expectation that it will be done on the same day as depression is first diagnosed.

(d) Increasing or decreasing the QOF point values: further on during this morning session the re-coder GP explained how increasing or decreasing QOF monetary value worked. The game is to find the right balance according to each situation: if a GP practice increases its register for a particular condition it has a 'dilutional' effect in terms of QOF points' monetary value, whereas when it reduces the register for a particular indicator it has a concentration effect in terms of QOF points monetary value.

Practicing dilutional strategy: at the end of this morning session, the GP summarised the main strategies involved in improving depression QOF points. This can be understood as a case analysis of a QOF points' enhancement strategy. In the case of QOF depression indicators, it involved a relation of the registered patients with depression (the 'ongoing' cases) with those 'newly' diagnosed as depression in the current financial year. The latter has to conform within a quality range standard set by each specific condition. The following

conversation illustrates the dilutional effect, which increases the chances of getting more money by decreasing the QOF points value allocated to that particular condition.

GP11: *Uff!…right, OK…going back to what I was showing you about…right, OK… if you look at it there…hmm…the lower limit…is 50 [%] and upper limit is 90%*...[quality range standard].

AHN: *Let me take a picture of this…the score* [taking a picture]*…OK… it has to focus* [talking about the tablet's camera]*...I think is OK, yes…*(Figure 8.3).

GP11: *OK, so…for between 50 and 90…it's about 40…40% range…OK…and it goes up to every percentage…so, basically, every 2% you will get two points…you will get one point…*

AHN: *Every 2%, one point…*

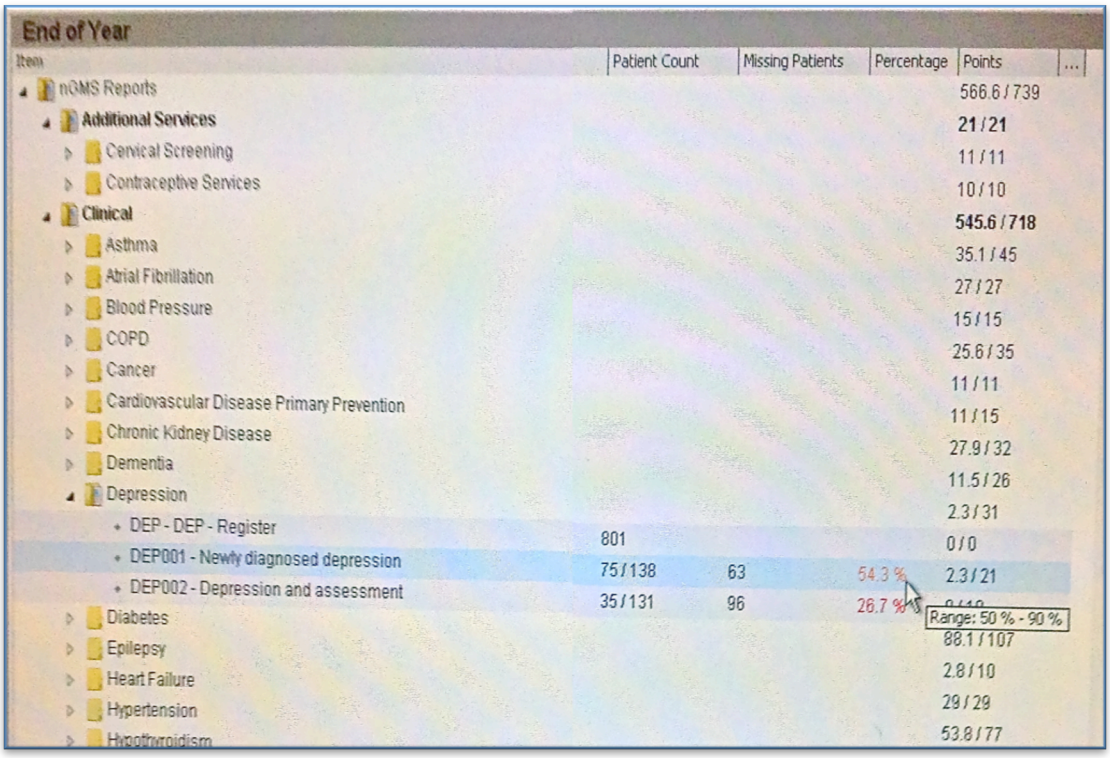


Figure 8.3. The depression indicators: 801 patients registered, 138 newly diagnosed and 131 needing to be reviewed. It shows the QOF range of achievement for newly diagnosed depression (50-90%) and practice current situation for DEP001 54.3% (amber colour) and DEP002 26.7% (red colour).

GP11: *OK, because you've got 4.3% over* [50%] *we got 2.3 points…OK, basically is two and quarter points…OK, so ((long))…hmm…the more points you get, the more percentage you get, you get more points…so it doesn't…because…if you get to the higher percentage, you get*

more points for your denominator…OK…so, if your denominator is…large…but you don't achieve the points…it's counterproductive…

AHN: *It's counterproductive, OK...*

GP11: *OK, so in some ways…*

AHN: *But the amount of money…*

GP11: *…per points is higher, but is not that much higher…OK, so it's more…it's better to get more points, than to get more money…per points…*

AHN: *It's better to get more points…*

GP11: *…than more money per points…because you get more by getting more points…than you would get…by getting more money per points…((slightly laughing)).*

AHN: *Quite confusing…*

The confusion occurs because the parameter the GP is indirectly talking about involves the prevalence of the QOF condition, i.e. the number of registered patients for a particular QOF clinical indicator. Note in the above dialogue how precise the GP is in highlighting that the amount of money is higher if you have more patients 'but is not that much higher'. This implies that small variations or adjustments in prevalence can help practices reach QOF's maximum threshold. Hence, by playing with the prevalence and how they are managing in respect to that particular target it is possible to favour one or the other strategy (i.e. by doing dilution or concentration), as the GP continued to explain:

GP11: *OK, because…hmm…your ((long)) prevalence, OK, you have to have quite a big jump to get an increase* [in the point value]...

AHN: *So, if say…say…compared to…two practices…so, in my practice I have 100…say depressive patients, in this practice I have less…50…*

GP11: *Then, it would be different because it is quite a big gap…OK, so if you have…say…100 and I only have 90…it would be very similar…*

AHN: *…very similar, yeah…*

GP11: *Not…not much pounds per points…change…*

AHN: *Yeah, no, yeah…I know…I know what you mean…*

GP11: *OK, so if I can get more points…for less money…I get more money…*

AHN: *Yes, I understand…*

GP11: *OK, you have to have a big jump* [in prevalence differences]…

AHN: *To make…to make real difference…*

GP11: *To make real difference, yes…*

AHN: *So, by excluding some denominators you…you reduce the prevalence…but to a certain threshold that does not…hmm…put at risk the whole budget involved in…in…*[that indicator]*…because if you exclude too much you also lose…money as well…so…*

GP11: *You will lose…lose money as well on the number of points that you can achieve…if you can achieve all the points, great, do it, yes!…but not all of them we can achieve, OK, like in COPD…which is quite big, but we are getting there and those ones we need to achieve…that is…hmm…we are quite…low in our review process.*

The last phrase summarises the nature of trade-off induced by QOF. It is on those QOF indicators where 'not all of them we can achieve' that this 'fine-tuning' has to be brought in to secure practices' income.

Practicing concentration strategy: the second strategy is to reduce the practice's number of depressive patients to improve their QOF ratio. This strategy increases the QOF monetary point value, thus having a concentration effect. Despite having fewer patients registered for a particular QOF indicator, each patient becomes worth a little bit more, helping to improve practice overall monetary gain. The concentration effect produces more pounds per point and, consequently, increases the practice's earning power.

AHN: *That's what I'm saying with…with…hmm…with depression as well, the point or the value is based on the whole…*

GP11: *But…the depression is…hmm…different, because I'm reducing the register…so my pound per point will increase…*

AHN: *Oh, yeah, I've got you…yeah….*

GP11: *OK, it's that one which I…which I'm reducing* [the numerator]…

AHN: *Because you're not labelling them as…as…depression…*

GP11: *…as depression...OK, but the ongoing* [depression] *it doesn't matter, because it's still there, but will stay on my register…those ones only <u>newly diagnosed</u>…*

AHN: *Yeah…that will disappear* [newly diagnosed]…

GP11: *OK, but that one if I'm putting down as ongoing* [depression is] *still staying there…*

AHN: *OK…*

GP11: *It's the new one that I've said they're not depressed, they are depressed mood but <u>not</u> depressed, then the register will go down* [referring to depression registered patients on the computer screen above]*...OK…so, we can…we can put a note on that one…so register…*[taking note]…

AHN: *But, you won't receive any benefit for the ongoing…any money for…for continuity of care, because that's…*

GP11: *Yeah, but…the more you have…the more pounds per points you'll get…so, the <u>more</u> you have on your depression register would <u>determine</u> your pound per points…*

AHN: *OK…so despite some of patients […]…it's better to leave them as ongoing, rather than putting them as…depressive mood…*

GP11: *No, no, no, but…if they are ongoing, leave them as ongoing…*

AHN: *Yeah, but for example, for those we were working with, the newly diagnosed…hmm.hmm…we've recoded them as…depressive mood.*

GP11: *So, they are not on the register, so I'm losing them altogether…*

AHN: *So, you will reduce the…it will not be 801, will be less…*[reducing the register]…

GP11: *It will be less, yes, yes, yes…OK, because then…I want to achieve more for that one to get more points…so it's a trade-off, but you need to decrease your register by <u>lot more</u>…to get any benefit…then to get more points…is more…you know, you have…you have to have a big chunk…OK…*

The implicit monetary game-logic fostered by the QOF scheme is summarised in the above two strategies. The first dialogue covers the dilutional effect '*I can get more points for less money, [so] I get more money'*; whereas the second dialogue shows the concentration effect: '*I'm reducing the register…so, my pound per point will increase*'. Simultaneously, QOF

seems to incentivise a medicalisation process through the rationale that 'the more you have, the more pounds per points you will get'.

The morning session with the re-coder GP shed light on how much QOF is open to manipulation via IT systems. This approach to electronic patient records was framed as 'aftercare' to differentiate from coding that is performed during the actual consultation (Swinglehurst & Greenhalgh, 2015, p. 6). Swinglehurst and Greenhalgh (*ibid*) in their ethnographic study have documented that a doctor had to edit 'manually' 'over 200 patients' EPRs' in order to avoid being 'penalised financially for failing to offer detailed health checks to patients whose clinicians recognised did not fulfil the criterion "severe enduring" mental illness'. This behaviour goes beyond the issue or concern around the exception reporting.

Exception reporting has proper Read codes and rules; whereas the exclusion by relabelling or recoding what was previously performed is not technically permitted or, at least, expected in QOF. Therefore, an embedded plasticity resides in the QOF scheme that allows data to be made-up for monetary and 'quality' standard gains. Similarly, the same plasticity might occur at the policy-makers level where the criteria for adopting some of QOF indicators were non-evidence based, as in the case of depression (Dowrick & Frances, 2013), dementia (Le Couteur, Doust, Creasey, & Brayne, 2013), chronic kidney disease (Moynihan, Glassock, & Doust, 2013), which are leading to overdiagnosis and overtreatment (Heath, 2013).

CONCLUSION

The introduction of QOF depression indicators, in association with the multiple forces that made possible their transformations throughout the years, speaks about our own time; a time when government policies are deeply aligned with corporate interests. This is reflected in the way NICE's depression guideline has been used to legitimise the adoption of certain QOF indicators in general practice, but filtered by interest groups such as the pharmaceutical companies, as documented in QOF depression indicators.

At the macro-level, throughout the years general practice has systematically been centrally incentivised to prescribe antidepressant drugs by QOF induced logic of 'the more cases the better' for practices' economic gains. At the meso-level, general practice, as a local

institution, has been tied up both by income and quality standard requirements, as exemplified in the practice meeting agreement. This inevitably results in transfer of pressure from doctors and managers upon lower echelon healthcare staff in order to get more QOF points. At the micro-level, QOF's verticality produces various ambivalent feelings amongst staff in relation to its indicators. For example, some professionals perceived QOF depression indicators as intrusive and not appropriate or even as a 'waste of time'.

The high numbers of 'missing patients' in depression indicators demonstrate how QOF bureaucratic rules were overcome through the use of alternative labels. This idiosyncratic behaviour has undermined the clinical rationale for its adoption or, in the GP's own words, it has become 'immaterial'. Thus, QOF as 'intermediate category' links the macroeconomic political context with the ordinary activities of general practice.

Quality and Outcomes Framework artificiality has the potential to promote idiosyncratic behaviours, amongst them gamesmanship. Consequently, stretching the rules or producing new interpretations for each QOF unmet target (as the use of PHQ-9 in QOF 2013/14 contract) should be understood as part of the QOF 'big game' enterprise with its multiple facets. The QOF depression indicators agglutinate the 'intimately related dimensions of contextual constraints, meaning systems and individual experience' (Bibeau, 1988, p. 405).

This chapter demonstrates, by using QOF depression indicators as a thematic compass or in Bibeau's term 'intermediate category', the interconnectedness of policy-makers (macro-level), general practice local institutions (meso-level) and individual health practitioners (micro-level). This tridimensional approach allows for a better understanding of the QOF scheme and of some of the consequences of its monetary inductive power.

The above idiosyncratic behaviours should be seen as a tip of an iceberg where gamesmanship represents only a surface of deeper and bigger political and socioeconomic approaches to health. These are, indeed, a space for lucrative 'commercial enterprises' (Rabinow & Rose, 2006, p. 203).

Chapter Nine

QOF AS A BIOMANAGERIAL TECHNOLOGY: IMPLICATIONS FOR GENERAL PRACTICE

This chapter concludes my ethnographic account on the impact of the Quality and Outcomes Framework in the UK primary care. The thesis has analysed QOF as a biomedical technological driver to improve quality in general practice. In this regard, it has covered different spaces and interfaces with practice teams' usage of QOF ranging from managerial and administrative activities to clinical settings in two medical groups in Britain during the 2013/14 QOF contract year. Thus, it has illustrated the relevance of ethnographic studies and the anthropological approach to biomedical technologies, therefore contributing to expanding knowledge in this research area.

The complexity of general practice is shown through its multi-layered institutional spaces and the daily-life affairs of practice teams dealing with QOF as a biomedical technology. This study wants to make an important contribution to the field of anthropology, in particular, and for the academic world, in general, through a detailed analysis of a biomedical technology. It does so, by dialoguing with different scholars in an interdisciplinary fashion, coupled by a critical anthropological approach to QOF as a biomedical technology. To the best of my knowledge, this thesis provides a unique description and application of Foucault's concept of governmentality in the modern UK health system. No research on pay-for-performance schemes has explicitly applied Foucault's concept of governmentality and showed its relevance for explaining the implications of such biomedical technology both to general practice and public health.

Clearly, the QOF scheme represents an attempt to govern the vital processes of 'each and all' via sophisticated IT systems. Through a naturalised panoptic regime inside the general practice environment, QOF aims to optimise population health via systematic individualised biomedical interventions based on a high-risk preventive strategy. This approach to health makes QOF symbiotic and vital for the NHS internal market and the UK bioeconomy. In a neoliberal environment, health as a commodity has insinuated itself further implemented into the NHS through QOF detailed pricing mechanism based on the exchange of patients' token information. In other words, QOF's fragmentary approach to bodily

processes commodifies ‘body-bits’ into ‘body-bites’ to be traded within the UK internal bio-market. This process represents an important governance strategy in animating the UK bioeconomy by making biopower, through the QOF scheme, a source of biocapital. Thus, this thesis shows the depth and breadth of anthropological approaches to the field of biomedicine, by shedding light on the biocapitalism of health through QOF and its strong bonds to the UK bioeconomy.

For the rest of this chapter I firstly reflect, discuss, and summarise the thesis and its main research findings in order to put things into perspective and to have a better understanding of QOF’s impact in general practice. Secondly, I address some strengths and limitations of the present research in a reflective way. Thirdly, I highlight some of the implications of the present research results to both policy-makers and researchers, followed by a brief conclusion.

REFLECTIVE DISCUSSION AND SUMMARY

Symbol of a cultural shift

Chapter Two offers a genealogical account of QOF by discussing the influences of political and economic forces in shaping general practices’ cultural distinctiveness. Historically, general practitioners in the UK have been struggling to be recognised as important as consultant doctors, who traditionally enjoy higher social prestige and have better salaries. Even today, the status and power of consultants can be influential in young doctors’ career choice, as most of them want to become a specialist in a particular part, system of the body or biomedical technology.

In response to the highly technological and more “scientific” consultant environment, GPs have developed a discourse of holism, community, and patient centeredness, regarding themselves as the ultimate advocate of patients’ health. This discourse was backed by the development of several consultation models (biographical, biopsychosocial, organismic) coupled by GPs’ traditional 24/7 care commitment and personalised patient lists. This was supported by studies showing that 80-90% of clinical cases could be dealt by GPs in primary care (Starfield et al., 2005). This eclectic, highly individualised, and personalised type of care, has created almost a mystical aura around GPs, materialised by their independent contractor status as ‘autonomous’ professionals. In this contract arrangement, GPs have been

predominantly paid by a capitation system, which privileges the whole person, rather than a series of diseases and targets or services. This, of course, produces a variety of practices and approaches to care, and to some extent, have been seen as the richness of this branch of medicine. Moreover, the GPs' cultural environment has been backed by several intellectuals both in the academia (Barbara Starfield) and in the practice of general practice (e.g. Ian McWhinney, Iona Heath). In this context, professionals themselves and their training programmes have framed the quality standards in general practice. Thus, this discourse and practice as a whole can be seen as a contra-hegemonic stance, when contrasted with the hegemonic biomedical model and hospital-based medicine.

The biomedical model of practicing medicine was regarded as mechanistic, fragmentary and decontextualised, with patients having little control over their care. However, the introduction of the quasi-market environment within the NHS produced a split purchaser/provider relationship arrangement. In this new frame, the government wanted general practice to be more accountable and to offer better value for money quality services. In line with the government's new managerial style, Pereira Gray et al. (1986, p. 1314)'s discourse typifies the 'intellectual battle' occurring in establishing quality standards in general practice: in the 'absence of any substantial accountability, makes it difficult to convince government or colleagues in the hospital services that expenditure on primary health care represents value for money'. The 1990's contract represented the first attempt by policy-makers to address quality in general practice by introducing some population preventive activities and targets. Nonetheless, this contract was not welcomed, because it threatened GPs' autonomy and their 'medical culture' at a time where their morale was high. It would take more than 10 years for a new paradigm to shift 'GPs' culture' with the advent of evidence-based medicine (EBM).

With the introduction of EBM, GPs have been co-opted into the biomedical model which initially produced a framework that levelled all physicians, regardless of their position in the different branches of medicine (Harrison, 2009). Science has been revered as the 'gold standard' for assessing the quality and the effectiveness of a biomedical intervention in a systematic, 'neutral', and 'objective' way (Roland, 2004). In this context, GPs were seduced by the EBM paradigm, which allowed a 'common language' for measuring the effects of an intervention and even to challenge consultants' decisions. The problem with the EBM was that GPs' contra-hegemonic discourse was weakened, as most of what it meant to be a GP

could not be 'measured' and variability of care became a sign of sub-standard medicine. The EBM approach gave prominence to populations and probabilistic reasoning that cannot measure the individualised, tailored and complex cases seen by GPs, usually excluded from randomised controlled trials (Barry, 2006).

As discussed in Chapter Two, the pursuit of 'quality' in primary care moved gradually away from an individualised type of care to a population model of care, a process where patients tend to be anonymised, as they used to be in the hospital-based medicine model (i.e. the patient of 'bed number X'). Taking a Gramscian approach to culture, which entails how 'class realities are lived' (Crehan, 2002), the QOF scheme possibly represents an important cultural change in GPs' clinical reality (Kleinman, 1978). As Gramsci suggests:

> The supremacy of a social group manifests itself in two ways, as "domination" and as "intellectual and moral leadership". A social group dominates antagonistic groups which it tends to "liquidate", or to subjugate perhaps even by armed force, it leads kindred and allied groups. (Gramsci, 197I: 57-58; in Kurtz, 1996, p. 106)

Thus, within the NHS, general practitioners tended to represent a 'subaltern medical' group that historically tried to overcome their low-status rank. Hence, it might be argued that QOF, representing the hegemony of the biomedical model, has induced a 'second nature' in general practice (Pizza, 2012), a process whereby the efficient use of intellectual (through EBM discourse) and coercive means (e.g. the governance system and monetary incentives) convinced large numbers of GPs to adopt a new 'convention and practice' (Napier et al., 2014), i.e. a new culture more aligned with the dominant group discourse of quality and best practice. As McDonald, Checkland, Harrison and Coleman (2009b, p. 1200) point out, 'the QOF component was largely informed by the input of academic advisers (Roland, 2004) or, in Freidson's terms, medical (knowledge) elites'. Consequently, without the intellectuals' role in systematically infusing the EBM model into medical education and GP training programmes (Roland, 2004), as well as the practice of medicine in line with the socioeconomic model, any cultural change would not have succeeded in altering the environment in general practice. According to Gramsci, cultural change is as fundamental as economic forces, and intellectuals have a relevant role in this regard. As Crehan (2002, p. 2) points out, culture for Gramsci entails the 'issue of class and inequality that is undogmatic, nuanced and never economically reductionist'.

Thus, multiple forces have played out for QOF to come to existence. For instance, the 2004 contract itself was considered by some GPs as a 'bribe to implement a population-based disease management programme' (Mangin & Toop, 2007, p. 435). This is not totally wrong when placed against GPs' economic gains during the first three years of the programme (e.g. 58% income increase) and the 'monetary incentive' to drop out of the 24/7 care commitment. To affirm that this policy was voluntary is to deny its political intention in transforming general practice in accordance with political and economic interests. As Franklin (1999, p. 94) highlights:

> The first early phase of technology often occurs in a take-it-or-leave-it atmosphere. Users are involved and have a feeling of control that gives them the impression that they are entirely free to accept or reject a particular technology or its products. But when a technology, together with the supporting infrastructures, becomes institutionalised, users often become captive supporters of both the technology and the infrastructures.

This feeling of captivity was metaphorically expressed by practice teams as a QOF 'monster' (Chapter Six, p. 159) that needed to be fed and taken care of, since they are trapped by its monetary incentive and 'quality' standards. As McDonald et al. (2009b, p. 1204) state, 'strictly speaking, and even where individual GPs have reservations (as we have seen), practices have chosen to exchange a degree of autonomy for the financial and other rewards that accompany these new developments'. Thus, within this working environment, it seems difficult to find a cultural distinctiveness in general practice, framed as a holistic approach to health, since 'a decade after its introduction QOF has become embedded as part of the identity of primary care in the UK' (Ashworth & Marshall, 2015, p. 394). This 'cultural shift' might be a contributory factor to the downward trend in population satisfaction with GPs, 'reaching 71 per cent in 2014, the lowest reported level since the survey began' (The Kings' Fund, 2015).

Biomanagerial 'dispositif'

Chapter Four explicitly uses Foucault's concept of knowledge/power and disciplinary technologies of the self as an analytical compass to explore QOF's apparently neutral clinical governance and quality assurance scheme in general practice. This chapter highlights general practice and its clinical settings as a power-relation space, which operates at a 'micro-level' – the microphysics of power through sets of specific practices' (Gordon, 1991, pp. 3-4). This research allowed tracing QOF as an updated materialised IT version of Foucault's concept of

governmentality, which harbours both the disciplinary approach to individual bodies, helping people monitor themselves (anatomopolitics), and the population health management: morbidity, mortality and longevity (biopolitics).

As a surveillance system in clinical settings, QOF is a powerful *dispositif* due to the intense use of computer software packages (e.g. System-One). In this context, the anatomopolitics pole is realised through disciplining individual patients into a biomedical 'quality' concept of health. This is carried out by a constant warning system (pop-ups, drop-boxes, icons on the computer screen) that pushes practitioners to do clinical reviews and measure patients' health through a series of bodily biomarker parameters that are used as 'gold standard' of good health control (e.g. haemoglobin A1c as a parameter for good diabetes control). Thus, through a sum of individual interventions the QOF scheme aims to improve the other pole of Foucault's biopower concept: biopolitics. For example, by financially incentivising general practitioners to offer long-acting reversible contraception methods (LARC), QOF aimed to reduce the number of unwanted pregnancies, especially in adolescents; and by promoting the spread use of statins to reduce individual patients' cholesterol level, as a primary preventive action, it hopes to impact positively upon the population level of cardiovascular mortality.

Clearly, behind this monetary incentive scheme, the government wants to increase control over individual patients, depicted by a managerial team arrangement that chases patients and brings them to the practice to be scrutinised, reviewed, and probed with the aim of improving population macro health determinants. As Checkland et al. (2008) have reported, some practices have adopted a zero tolerance for 'DNA patients' – those who usually 'Did Not Attend', in order to improve their patients' uptake profile. Simultaneously, in the working environment this IT surveillance system has fostered a 'panoptic regime', or in the participant's own words, a 'big brother' regime after George Orwell's book, 1984.

According to Lock and Nguyen (2010, p. 11) 'biomedical technologies' 'encompass a broad range of practices and procedures that are made use of not only in clinical care, but also in both the production of scientific knowledge and standardised practice'. However, as the QOF brings with it elements of audit and business management, it might be better defined as a 'biomanagerial technology': a blend of protocols derived both from the managerial/financial sector and clinical guidelines aiming to assure quality control of body

biomarkers' processes and outcomes (i.e. level of cholesterol, haemoglobin A1c, and so on), based on the universal and standardised concept of the human body. This 'biomanagerialism' introduced into general practice is in line with the material, political and economic environment of today's British neoliberal policies due to its complex 'marketization, autonomization and responsibilization' by individuals to manage their own affairs and with a 'prudential eye on the future' (Rose, 2006, p. 4). As a biomanagerial technology, the QOF scheme reduces health to a biological level that every individual needs to be managing, while simultaneously creating and animating the bioeconomy, which transfers public money to private corporations.

Thus, the QOF as biomanagerial technology represents a sophisticated technoscientific mode of governmentality. This is being fostered in high-income neoliberal economies due to its intense commercialisation of human bio-values, helping to create a bioeconomy and biocapital circuit (Rose, 2006). Essentially, the QOF as biomanagerial technology has a very 'modernistic' design and constructs human bodies in a way that is attractive to the current socioeconomic system. The biomedical model, which underpins this technology, allows it to 'enframe' the human body in a calculable and coherent way that can be displayed as a 'standing-reserve' (Heidegger, 1977). Hence, this biomanagerial technology is advantageous over other approaches to health and quality, since it has a prospect of generating 'a certain economic profit, [calculability], and a certain political utility' (Foucault, 2003, pp. 32-33).

Nevertheless, current medical evidence supports that traditional risk factors such as cholesterol, obesity, diabetes and so on, account for just 1/3 of the toll of cardiovascular death (Marmot & Brunner, 2005), the other 2/3 being linked to the 'social gradient of health'. Two main factors influence the social gradient in health: the subjective sense of control that people have over their life circumstances (labour and family), and the degree of social cohesion (i.e. a supportive network of family, friends and/or co-workers). In other words, the greater the social cohesion, the better the health outcomes for both rich and poor people alike (Helman, 2007). Commonly, in less unequal societies the sense of belonging, the social cohesion, and security are larger and, therefore, the beneficial health effects equally occur for the wealthy in these societies (Wilkinson & Pickett, 2010).

However, this evidence is of no economic interest, since it does not prioritise the individualised preventive strategy (Bayer & Galea, 2015). On the contrary, this biomanagerial approach to health has produced 'the largest national primary care' bio-database in the world (Kordowicz & Ashworth, 2011, p. 84). This bio-information database has enormous bio-value that it is essential for pharmaceutical corporations for marketing new products and strategies in order to improve their business in the name of 'public health'. This can be read in the NHS Choice 'your health and care records' in the patients' FAQs, question number 22: '*In most cases, researchers can carry out their studies using information that does not identify you. Occasionally, however, medical researchers need to use information that does identify you'* (HSCIC, 2014c). This information is not sold, but is available as long as the research companies have managed to obtain the '*legal approval and they do so following independent advice from the Confidentiality Advisory Group (CAG)'* (*ibid*). Hence, the QOF scheme fits quite well within global bioeconomy arrangements with the use of ethical discourses to legitimise its practice (Rose, 2006).

Commodification in general practice

The theme of commodification discussed in Chapter Five is clearly described and highlights how this biomanagerial technology merges into a commercial type of medicine by reifying bodily token-information as £-QOF. This fetishised form of commodification exemplifies how health is being treated as a matter of economic interest. What used to be a whole approach to people's health has been sliced into bits of reified information that can be stored up, and later, at the end of financial year, claimed as practices' revenue. This commodification process is not necessarily related to the amount of work involved in any given health activity, but its value is allocated according to policy-makers' consensus. At the local level, practitioners do not know why certain conditions are worth more than others.

According to Karl Polanyi (2001), the process of commodification of labour, land and money was vital for the rise of the self-regulated economy of market. Polanyi (2001, p. 75) argues that labour and land cannot be commodified, as they are originally not produced for sale, they cannot be 'stored or mobilised' as in essence they respectively represent 'life itself' and 'nature'. However, as Heidegger points out, modern technology 'enframes' nature's vitality in a form of 'standard reserve' that renders its calculability. This is a kind of fiction, though an essential step in today's market economy, as Polanyi writes:

> The commodity fiction, therefore, supplies a vital organizing principle in regard to the whole of society affecting almost all its institutions in the most varied way, namely, the principle according to which no arrangement or behaviour should be allowed to exist that might prevent the actual functioning of the market mechanism on the lines of the commodity fiction. (Polanyi, 2001, p. 73)

The NHS represents the reminiscence of a strong welfare state aiming to protect human beings when they fell sick, and not a space for the market economy. In other words, the NHS's approach to health prevented the actual functioning of the market mechanism along the lines of the commodity fiction. Nevertheless, since Thatcher's conservative government this protective bubble has gone into a slicing process, framed within a market economy of 'buyers and sellers'. This process has created an artificial internal-market that should self-regulate prices and demands for health services, which inevitably (the argument goes) will drive quality standards up through competition of providers within this artificial internal-market. Therefore, this internal-market can be seen as the first step in treating health as a 'commodity' regulated by a purchase/provider framework within the NHS.

Contrary to social scientist Stephen Harrison (2009, p. 190), who framed the QOF scheme as a 'conceptual' commodification process in the NHS, the present anthropological investigation found that a quite 'literal'[6] commodification process is occurring in UK general practice. The QOF scheme allows for a real 'good' (i.e. QOF token-information) to be 'alienated' and 'exchanged'. Different from the US 'free' market regulations, in the UK the commodification process occurs through its internal market arrangement, which can 'decommodify' particular 'bits' of patients care, by removing or retiring QOF indicators. In this case, the trade is internally oriented between government and GPs, bypassing the users of general practice services. By 'salami-slicing' what used to be a more holistic type of care and pricing patients' bodily-component parts, the government opened up a 'Pandora's box', which is the capitalist approach to health. Therefore, the pricing and fragmentation of care provision is paving further a way of privatising the NHS.

This context places a challenge to general practice's ethos. Practices simultaneously have to be spaces of care and spaces of lucrative enterprise. In this process, doctor-patient healing relationships and GPs' professional ethics are being gradually blurred by the QOF's

[6] Literal commodification: 'Literal commodification is the treatment of goods and services as if produced for exchange, rather than simply for consumption' (Harrison, 2009, p. 190).

induced commodification process. This ethnography demonstrates some of the risks and concerns of applying the 'business models to health cultures of care'. As Napier et al. (2014, p. 1631) highlight:

> When public organisations mask private gain, those who would otherwise contribute to the public good lose trust in collective action and turn instead to strategies for improving self-worth. When resources are limited, self-worth loses its collective and cooperative meaning, invariably becoming self-centred.

The QOF scheme, as a biomanagerial technology, is fostering a commercial mentality and ethos in general practice from inside the NHS, strengthening the ethics of commerce, market and business, prompting practice teams to behave as 'data harvesters' (Loxterkamp, 2013). This situation is particularly evident as practices reach the end of the financial year, portrayed as a 'time of madness', 'panic' and 'nightmare': the Mad March Hare phenomenon.

Behaviour modifier device

Chapters Six and Seven show that the biomanagerial environment in general practice has induced important changes in team practice behaviours. Since the QOF scheme represents a significant part of practices' income, general practice has changed its default to guarantee that a considerable amount of QOF-tasks are performed properly. This was portrayed as 'playing the QOF game'. In organising for the QOF game, general practice has furthered the work division, mimicking several specialised clinics based on a disease model, such as COPD/asthma, cardiovascular checks, diabetes clinics, and so on. The QOF scheme as a biomanagerial technology has stimulated a work specialisation process, handled by specific professionals (practice nurses specialised in a particular condition) that provide care by following a series of detailed steps and protocols (via e-templates) on how to treat or manage specific conditions or diseases. Harrison (2002) has framed this NHS approach to health as a sort of Fordism, based on a scientific-bureaucratic model of practicing medicine.

Ursula Franklin sees this kind of technological innovation as prescriptive by nature. These 'prescriptive technologies constitute a major social innovation. In political terms, prescriptive technologies are *designs for compliance*' (Franklin, 1999, p. 16). Therefore, this prescriptive working environment tends to be internalised as normal and necessary for delivering quality standards of care, leading to an acculturation process where 'external

control' and 'internal compliance' become the norm, leaving 'little latitude' for practitioners' 'judgement' (*ibid*).

Despite some QOF targets lacking strong evidence, they are treated as technical issues and not dealt with regard to their clinical relevance. The monetary link attributed to each QOF indicator leaves GPs in a situation of either having to follow them or to hand the tasks over to nurse teams to deal with. Thus, QOF prescriptive type of care ends up affecting mostly nursing teams via e-templates, while GPs have a complementary role. From the point of view of professionals' autonomy, the QOF scheme has dramatically reduced it, and clinicians have to 'jump through hoops' to secure both practice's income and 'quality' standard social recognition. It is clear that this 'having to do it', as complained by some participants, reinforces the idea that QOF is based on 'external control' and 'internal compliance'.

Nevertheless, as discussed in Chapter Seven, practice teams actively find ways to overcome or to adapt to this biomanagerial technology. This chapter describes several ways of producing data by stretching the QOF rules that although 'not illegal' is a process that I called gamesmanship. Gamesmanship, to some extent, represents a counterstatement or a response to the QOF's top-down, inflexible, and artificial nature. This has become an integral part of QOF activity in order to make 'QOF work', and to secure practices' revenue. Moreover, practice teams have a clear understanding that the QOF scheme measures targets or frames and not necessarily the quality of the health care delivered. Hence, QOF induced new roles in general practice (i.e. the GP re-codifier), and new approaches to the use of the telephone either to secure patients' informed dissent or to undertake patients' reviews. The computer free-text option is explored either to avoid QOF-tasks (as in the case of depression indicators) or to avoid damaging a good previous blood pressure record. Auto-consultation allows for a 'short version' of clinical reviews that save practice teams' time and reduces the QOF's intrusiveness, though reframing QOF original clinical review standards. As stated by the managerial staff, the practice of QOF entails a massive usage of a range of manipulative strategies in terms of coding, and different ways of including or excluding patients from certain QOF targets. Thus, QOF produces a 'technological drama'.

Bryan Pfaffenberger (1992, p. 505) points out that a 'technological drama is a discourse of technological "statements" and "counterstatements" in which there are three

recognisable processes: technological regularisation, technological adjustment, and technological reconstitution'. Chapters Six and Seven give an account of the 'reconstitution' of QOF, where practice teams actively work to produce the data required for guaranteeing practice incomes and quality standards. These behaviours and re-constitutional practices of QOF have important implications for data quality production and its use.

QOF and Evidence-Based Medicine

Chapter Eight uses QOF depression indicators as 'mediating categories' to navigate through different socioeconomic and political levels. This ethnography is the first study that has looked at the evolution of QOF depression indicators since they were introduced in 2006/07. This account is based on government policies and official data (secondary data) as well as on the debate over the indicators' scientific validity among researchers. By highlighting the evidence fabrication through QOF depression indicators, researchers' 'esoteric circle' shows greater level of uncertainty within its collective thought style, i.e. the biomedical model (Fleck, 1979). In this regard, it explains how the fluid discussion and uncertainty around the use of formal severity-assessment questionnaires (SAQs) that were going on at the research epicentre (esoteric), were gradually transformed externally (exoterically) into a more rigid framework, and therefore, creating a mix of feelings among practitioners over their validity.

In this evidence fabrication process, potential biases favouring the inclusion of QOF depression indicators in the overall framework were addressed. Since the inception of QOF depression indicators there was a lack of solid medical evidence regarding the introduction of both the PHQ-2 screening questionnaire and the SAQ itself. The latter points to potential conflicts of interest, since researchers promoting the inclusion of SAQs as QOF indicator were influenced by pharmaceutical corporations. Furthermore, it documents how policy-makers have used QOF points' allocation to incentivise the use of SAQs in the hope of changing health staff approaches to depression and the subjective aspects of mental health.

Therefore, different interest groups influence QOF's 'EBM' indicators and potentially the pharmaceutical industry might be using such a quality assurance scheme for improving their sales, as claimed by Spence (2013). The systematic financially incentivised QOF depression indicators via a robust IT system have contributed to the medicalisation of mental health. In this regard, the British Medical Journal has recently described EBM as a movement in crisis due to the influence of pharmaceutical corporations in research development, in

selective publication strategies, as well as in influencing policy-maker decision boards (Greenhalgh, Howick, & Maskrey, 2014).

Since 2009, the QOF indicator criteria and thresholds are reviewed annually by the NICE to assure that they meet the best available medical evidence (Doran et al., 2014). However, even NICE has been criticised for potential conflicts of interest in its 2014 clinical guidelines on cardiovascular risk assessment. Despite all critics, in 2015 NICE has given its support to the introduction of a new QOF indicator for 10% risk cardiovascular assessment and use of statins in the 2016/17 QOF contract-year (Price, 2015). The promotion of widespread consumption of statins via 'quality' monetarily incentive schemes cast doubt on NICE as a credible institution. The QOF biomanagerial approach to health reveals the intricate relationship of EBM, clinical governance institutions (e.g. NICE), and pharmaceutical corporation interests. 'It is difficult to escape the impression that primary care policy is being influenced more by an unhealthy combination of ideology and political pragmatism, than by the research evidence of what works' (Ashworth & Marshall, 2015, p. 394).

Another dimension in Chapter Eight entails the discussion around the meso-institutional level and micro-practical level arrangements to deal with the artificiality brought into general practice by the QOF scheme. The PHQ-9, once considered a gold standard of best practice, was used as 'counterstatement' tool to overcome unmet QOF targets. This demonstrates practice teams' agency in adjusting the QOF ratio to their needs in order to secure practice quality standards and incomes. Such induced behavioural changes show that data production linked to monetary incentives bears the same bias (or problems) as other kinds of fee-for-service reimbursement modalities, since all are based on a principle that the more 'you produce' the more 'you get' (Robinson, 2001). Chapter Eight, therefore, presents a good picture of the intensity of commercial influence both in the National Health Service and in the UK general practice.

STRENGTHS AND LIMITATIONS

This research provides a unique account of the QOF as a biomanagerial technology and highlights important changes in the UK general practice as a result. The ethnographic

approach was adequate and powerful study design for an in-depth research into this biotechnological innovation. The access gained by the researcher to a space that is considered a 'hard one to get access to', coupled by his outsider (institutional) and insider (physician) status is one of the research strengths. Another aspect of its boldness refers to the researched sites, which are training practices, meaning that the phenomenon observed happened in good quality standard general practices. By focusing on the technological innovation itself some findings are certainly capable of generalisation, despite studying only two GP surgeries. Four of the research results can be regarded as generalisable:

(1) The QOF scheme as a surveillance mechanism represents the soul of this biomanagerial technology. It might be argued that some sort of 'surveillance' was already in place before the QOF era, but this was rather patchy and not systematic or monetarily incentivised across the country. Before the introduction of QOF, general practice health teams could be more flexible in their decision-making and no managerial team was overlooking staff performance on specific indicators (e.g. whether or not a statin was added, whether or not patients smoking status was updated, and so on). The implication of QOF to health professionals' autonomy is considerable, as GPs' independent contract status has become immaterial, at least from a clinical perspective.

(2) Treatment of health as a commodity based on patients' token-information exchange is inherent in the monetary link attached to each QOF indicator criteria. It can be argued that commodification of health in the NHS is not a new thing. However, this research documents that for the first time in the general practice commodification is occurring at the interface between patients and general practice health staff. The QOF scheme has contaminated health professional-patient relationship with the requirement of a commercial type of medicine as never before. Thus, the role of health professionals as patients' advocate has been corroded.

(3) Evidence-based medicine and NICE, which should account for the rigour in the QOF 'quality' assurance scheme, are clearly tempered by different interest groups, including pharmaceutical companies. The QOF scheme shows that EBM, as a sign of scientific rigour, has gone astray. The QOF scheme's overemphasis on a high-risk preventive strategy as a way of addressing macro determinants of health is

questionable ethically and scientifically, since it leads to the medicalisation of the health/disease phenomenon via the inadequate use of biomedical knowledge.

(4) QOF seasonality is another generalisable phenomenon, although the degree and impact on practices might vary. The way researchers have addressed QOF gives an impression that the data production is a smooth process evenly distributed throughout the financial year. However, as documented in Chapter Five, practices had more than 50% of their QOF targets left to be tackled within four months or so. As mentioned by some of the participants, the QOF seasonality has been the norm in preceding years. To the best of my knowledge, this thesis is the first to document the seasonal character of QOF, which has important consequences for the working environment in general practice, patients' access, and professional behaviour. The QOF seasonality is a complex result of various forces such as (a) the constant mutability of QOF indicators, rules, cut-off points and non-availability of new Read codes at the beginning of a financial year; (b) patient non-compliance meaning QOF tasks accumulate at the end of financial year; (c) practice coping organisation and size (small practices might have different challenges as they reach the end of the financial year); (d) template characteristics might hamper the data collecting process; (e) turnover of health professionals and the use of locums; and (f) professional unwillingness to do QOF-tasks. Therefore, the chances are great that this phenomenon is likely to be seen across UK general practice. QOF seasonality hugely influence practice teams behaviour. Hence, changes in practice team behaviour due to QOF are more likely to fluctuate in degree according to the time of the financial year and how behind the practice teams are in terms of QOF requirements. Different arrangements (as counterstatements) to deal with QOF artificiality can be seen across UK general practice. This account demonstrates them happening in a good standard general practice environment.

This research did not comprise practices with personal lists of patients. These might have a different approach to patient care considering themselves as more 'holistic' practices. Similarly, small practices (single handed or two-to-three partners), which might deal with QOF requirements in a different way, were not included. Low-score QOF practices might have opted for a more patient focused approach balancing potential economic gains/losses with regard to patients' response to clinical reviews (Alderson et al., 2014). Both researched

practices used the same software package and some of the features illustrated here might be peculiar of System-one software. However, Swinglehurst and Greenhalgh (2015) found some data make-up in general practice using a different software package, suggesting that this behaviour is not software dependent *per se*.

The present research was done under the influence of 2013/14 contract that introduced important changes into the overall scheme such as the biopsychosocial assessment in depression indicators, tightening the targets for blood pressure and diabetes, and so on. Additionally, the timeframe of this research (from November/2013 to April/2014) covered a particular period of the overall QOF financial year.

As discussed in Chapter Three, being just one researcher in the field reduced the possibility of covering what was going on at all the sites, simultaneously. If I had got the chance to be in GPs' surgeries two months in advance, I might have increased my chances of attending practice 'A's QOF meetings before March. To build trust in a short period of time was quite a challenge, as some of the issues around QOF might have been seen as quite sensitive or having the risk of being misinterpreted. My overall impression, however was that practice staff were only too willing to discuss QOF and its implications with me. Being seen as an 'outsider' from Brazil and a 'curious GP', might have led to a more candid interaction with practice teams, reducing some of the barriers, and facilitating access to vital information regarding this biomanagerial technology, which others might have found more difficulty obtaining.

IMPLICATIONS FOR POLICY-MAKERS AND FUTURE RESEARCH

In the field of Public Health and General Practice this research expands the knowledge of health technological innovations aiming to improve the quality of health services in primary care. It sheds light on some of QOFs' unintended consequences, which might have important implications for both researchers and policy-makers. The present research suggests that the QOF scheme has important side effects, which further questions its validity. These findings are in line with recent publications on QOF from quantitatively designed research (Kontopantelis et al., 2015), as well as previous qualitative studies (Checkland et. al., 2008) that question its validity as a tool for improving health care standards. Napier et al. (2014, p.

1631) suggest expenditure on health should be placed in ‘actual care’ rather than ‘expensive procedures and management cultures’.

For middle-income countries such as Brazil, which have not reached an equitable public health system (Paim, Travassos, Almeida, Bahia, & Macinko, 2011; Macinko & Harris, 2015), the use of this biomanagerial technology might drive important resources into activities that can render little actual patient benefit on better care.

Potentially in-house research environments exist that need anthropologists’ contribution in the field of public health innovations and biomedical technologies, of which the present study is an example. In regard to this research, it has not covered patients’ perspectives on the subject, an important area that needs to be addressed by anthropologists. Additionally, the study of other levels within the spectrum of policy-making is a relevant research space, as it generates new technologies such as QOF. For instance, the National Institute for Health and Care Excellence (NICE) is a place that needs anthropological oriented research in order to understand how evidence is being produced in the UK. This might have important effects for policy-making decisions.

This research indicates potential correlated areas of investigation such as educational institutions and practices, since similar phenomenon might be occurring there as well. Marilyn Strathern (2000)’s accounts of audit culture in the education sector was inspirational at the beginning of my approach to the health sector. There might be scope for studying other areas where the same processes can be seen.

CONCLUSION

The NHS remains an important asset of the UK welfare state as well as general practice continues to be its backbone. Throughout my fieldwork I met with committed practice teams and GP trainers. They were engaged either in delivering the best care possible to their patients or in providing the best teaching context for future GPs. As I have learned through this time in the UK, general practice errors are usually systemic in nature, rather than a consequence of an individual’s malpractice. The QOF scheme represents a top-down systemic interference in general practice that is producing important distortions, hidden behind the ‘quality’ data production. In primary care as in commerce, it seems that the UK

wants to replace local business, where customers used to have a relationship with their owners, in favour of more impersonal big supermarkets that change the local landscape and the relation with people.

To continue this metaphor, the QOF scheme as a biomanagerial technology is transforming UK primary care into fast-food-like general practice franchises that have to work in accordance with the demands of the franchisor-government and its economic interests. Undoubtedly, the biomanagerialism in general practice has intensified a kind of commercial medicine and commodified health from inside the NHS. The GPs' traditional advocate role has weakened in consequence. Conformity is a prerequisite for such technology either by having them 'jumping through hoops' that are all the same or to hand the tasks over to a protocol-following nurse to do. General practice in the UK is thus in a very difficult position to sustain its holistic principles and practices. The QOF scheme as a biomanagerial technology epitomises a cultural change in general practice based on a financial incentive system that subtly and not-so-subtly is transforming its clinical and non-clinical institutions.

APPENDIX A – Professional Staff Research Information Sheet and Informed Consent

Quality and Outcomes Framework (QOF) and its influence on General Practitioners' principles and practice

Chief Investigator: Dr Armando H Norman

Supervisors: Dr. Andrew J Russell

Dr. Claudia Merli

Project Information Sheet (for professional staff)

I am a qualified Brazilian GP currently undertaking a PhD research programme in Medical Anthropology at Durham University. The PhD research project entails an ethnographic study of a primary healthcare surgery with the aim of learning the effects of the Quality and Outcomes Framework (QOF) on primary care health professional, specifically on general practitioners' principles and practice. The novelty in this contract is the monetary incentive for physicians - based on agreed targets - to improve their clinical practice standards. In 2011, the Brazilian Ministry of Health introduced a particular form of monetary incentives based on agreed health parameters with family health teams and municipal health authorities. Moreover, some Brazilian municipal health authorities have already started some similar pay-for-performance scheme in primary care settings inspired by the Portuguese P4P model. For this reason, and because I am fortunate enough to be studying in the UK at the moment, I would like to carry out this research project to see how QOF works at the practical level and also how health staff understand this new model of delivering health services.

The ethnographic work basically consists in an immersion into the practice with the purpose of learning the context and social-interaction, as well as, gathering information. The data collection, which will be relatively open-ended approach, will help explore the workings of the practice in the context of the new General Medical Service contract: the new rules which govern the relationships and interactions within the sub-settings studied. The methodological techniques are basically of participant observation (shadowing style) which will involve interviewing members of staff, analysing documents such as data on QOF requirements and direct observation of ongoing events that will be taken and documented. The use of recording

devices (audio) for recording conversation will be used when talking with staff (with the consent of those involved) for further detailed analysis of the conversation.

All information given will be kept anonymous and some unattributable extracts from the conversations, as well as other sources of information such as documents and data may be used in writing up the PhD thesis to illustrate how GPs intertwine the QOF requirements within the care for patients.

Should you wish to discuss my project at any time, please feel free to contact me by the methods below:

Address: 3.14 Keenan House, Old Dryburn Way, DH1 5BN, Durham UK

Email: a.h.norman@durham.ac.uk

Phone: 07903528560

Consent Form to Participate in PhD Research Project from the Department of Anthropology – University of Durham

Title of project: The Quality and Outcomes Framework and its Influence on General Practitioners Principles and Practice

PhD Researcher: Armando Henrique Norman

Supervisors: Andrew J Russell

Claudia Merli

Date……..

This declaration certifies that I (insert name) _____ give my full consent to participate in the research project conducted by Armando H. Norman, Durham University. I have understood the aims and objectives of the research project and treatment of the final data set. The nature of the research has been fully explained to me including my rights to remain anonymous and withdraw from the research project at any time without further need for justification.

I (delete as appropriate) do/ do not give permission to use an audio recorder during interviews. I understand that this information will only be used as a memory aid for the purposes of transcribing the written material and details concerning my identity will remain anonymous.

If you agreed to be audio recorded during the interviews, please state below whether you would prefer your information to be destroyed after completion of the research project or to be retained by the individual researcher for future research use.

Thank you for your participation and cooperation with the research project.

APPENDIX B - Summary of Research Publications on QOF

Authors/ Year	Title	Study Period	Design	Setting	Sample Size	Main Findings
Alderson, S.L. et al., (2014).	Incentivised case finding for depression in patients with chronic heart disease and diabetes in primary care: an ethnographic study.	Not informed.	Ethnographic study drawing on observations of practice routines and consultations, debriefing interviews with staff and patients and review of patient records.	General practices in Leeds, UK.	12 purposively sampled practices with a total of 119 staff; 63 consultation observations and 57 patient interviews.	Case finding does not fit naturally within consultations; both professional and patient reactions somewhat subverted the process recommended by national guidance.
Alshamsan, R. et al., (2010).	Impact of pay for performance on inequalities in health care: systematic review.	Papers published between 1st January 1980 and 1st November 2008.	Systematic literature Review.	Not applicable.	22 studies were qualified for analysis.	Inequalities in chronic disease management have largely persisted after the introduction of the Quality and Outcomes Framework.
Alshamsan, R. et al., (2012).	Effect of a UK Pay-for-Performance Program on Ethnic Disparities in Diabetes Outcomes: Interrupted Time Series Analysis.	2007	Quantitative interrupted time series analysis of electronic medical record data of diabetes patients.	South West London, United Kingdom.	Data of diabetic patients registered with 29 family practices.	Universal P4P scheme did not appear to address important disparities in chronic disease management over time.
Campbell, S., et al. (2008).	The Experience of Pay for Performance in English Family Practice: A Qualitative Study'.	February to August 2007.	Qualitative Study: semi-structured interview.	Interviews conducted in 22 nationally representati ve practices across England.	21 GPs and 20 nurses.	QOF has changed the dynamic between doctors and nurses and the nature of the practitioner-patient consultation.

Campbell, S., et al. (2011).	Exception reporting in the Quality and Outcomes Framework.	October 2009 to March 2010.	Qualitative Study: semi-structured interviews analysed using open explorative thematic coding.	Interviews conducted in 27 general practices in the UK.	24 GPs, 20 practice managers, 13 practice nurses, and nine other staff members.	Exception reporting as an important & defensible safeguard against inappropriate treatment or over-treating patients. A minority of practitioners also saw it as a gaming mechanism.
Checkland, K., et al. (2007).	Ticking boxes and changing the social world: data collection and the new UK general practice contract.	December 2005 to May 2006.	Qualitative study: ethnographic study.	Two practices in England.	13 GPs; 9 nurses.	GP moved towards population based health care style; reduced patients choice; health task moving towards less qualified staff; increased surveillance; GPs expressed few such concerns, continuing to view their improved computer systems as neutral recording devices.
Checkland, K., et al. (2008).	Biomedicine, holism and general medical practice: responses to the 2004 General Practitioner contract.	November 2005 to May 2006.	Qualitative study: two linked ethnographic case studies.	Two practices in England and two in Scotland.	24 GPs; 15 nurses; and Six health care assistants.	QOF resulted in patients receiving a more biomedical. However, respondents continued to maintain discursive claims to holism.
Checkland, K., et al (2010).	The impact of the Quality and Outcomes Framework on practice organisation and service delivery: summary of evidence from two qualitative studies.	November 2005 to May 2006.	Qualitative study: two linked ethnographic case studies.	Two practices in England and two in Scotland.	24 GPs; 15 nurses and six health care assistants.	A move towards a more biomedical form of medical care; and changes to roles and relationships, including the introduction of internal peer-review and surveillance.
Dixon, A. et	Does general	Data	Quantitative	Not	The study	The findings

al. (2010).	practice reduce health inequalities? Analysis of quality and outcomes framework data.	analysis of QOF 2004/05 and 2005/06 contract.	data analysis of differences in achievement on clinical indicators.	applicable.	used data on 8339 primary care practices in England.	suggest 'that area-based initiatives to tackle inequalities have not yet had an observable impact on deprived practices'.
Doran, T., et al. (2008).	Exclusion of patients from pay-for-performance targets by English physicians.	April 2005 to March 2006.	Quantitative study based of secondary data.	Data extracted from clinical computing systems for 8105 general practices in England.	Exception reporting for 65 clinical activities.	In England, rates of exception reporting have generally been low, with little evidence of widespread gaming.
Dowrick, C., et al. (2009).	Patients' and doctors' views on depression severity questionnaires incentivised in UK quality and outcomes framework: qualitative study.	Not referred.	Qualitative Study: semi-structured qualitative interview study.	38 general practices in three sites in England: Southamp-ton, Liverpool, and Norfolk.	34 general practitioners and 24 patients.	It may have benefit by increasing patients' confidence that GPs are correct in their diagnosis and are making systematic efforts to assess and manage their mental health problems.
Gillam, S., et al., (2012).	Pay-for-Performance in the United Kingdom: Impact of the Quality and Outcomes Framework - A Systematic Review.	January 2004 to July 2011.	Systematic literature Review.	Not applicable.	94 studies were eligible for the review.	'Improvements in quality of care for chronic diseases in the framework were modest, and the impact on costs, professional behaviour, and patient experience remains uncertain.'
Gravelle, H. et al. (2008).	Doctor Behaviour under a Pay for Performance Contract: further Evidence from the Quality and Outcomes Framework.	Compare QOF contract years 2004/5 with 2005/6.	Quantitative: Multiple regressions of delivered quality, exception reporting, and prevalence reports on practice.	Not applicable.	QOF data from Scottish practices (n=916), and data on practice characteristics and on sociodemo-graphic and morbidity factors from	'QOF provides perverse incentives for gaming of exceptions and we find evidence that practices which performed worse in 2004/5 were more likely to game exceptions

					the 2001 census.	in 2005/6'.
Kontopan-telis, E., et al. (2015).	Investigating the relationship between quality of primary care and premature mortality in England: a spatial whole-population study.	2007 to 2012.	Longitudinal spatial study, at the level of the "lower layer super output area" (LSOA).	32482 LSOAs (neighbour-hoods of 1500 people on average), covering the whole population of England (approximat ely 53.5 million).	8647 English general practices participating in the QOF for at least one year of the study period, including over 99% of patients registered with primary care.	Higher reported achievement of activities incentivised under a major, nationwide pay-for-performance programme did not seem to result in reduced incidence of premature death in the population.
Lester, H., et al. (2013).	Implementation of pay for performance in primary care: a qualitative study 8 years after introduction.	From 23rd March and 30th April 2012.	Qualitative semi-structured interview study.	Participant from 23 practices across England.	26 general practitioners; Six practice nurses; 13 practice managers; Two other administrative staff.	'P4P indicators are now welcomed by PHC teams and GPs across generations'; 'Almost all GPs and practice managers described a sense of decreased clinical autonomy and loss of professionalism.'
Maisey, S., et al. (2008).	Effects of payment for performance in primary care: qualitative interview study.	2006	Qualitative semi-structured interview study.	Eastern England general practice with a broad range of socio-demogra-phic and organization -nal characteris-tics.	24 primary care clinicians: one general practitioner and one practice nurse from 12 general practices.	Non-incentivised activities and patients' concerns may receive less clinical attention.
McDonald, R., et al. (2007).	Impact of financial incentives on clinical autonomy and internal motivation in	November 2005 to May 2006.	Qualitative study: ethnography.	Two practices North West of England, one "Big practice" with	12 GPs, nine nurses, four health care assistants, one senior receptionist.	The QOF did not seem to have damaged the internal motivation of the GPs studied, although nurses

	primary care: ethnographic study.			registered lists of 12,000 and "Medium practice" patients 8,000.		expressed more concerns.
McDonald, R., et al. (2008).	Incentives and control in primary health care: findings from English pay-for-performance case studies.	November 2005 to May 2006.	Qualitative study: ethnography.	Two practices North West of England, one "Big practice" with registered lists of 12,000 and "Medium practice" patients 8,000.	12 GPs, nine nurses, four health care assistants, one senior receptionist.	It highlights the emergence of new tensions within and between existing professional groupings.
McDonald, R., et al. (2009).	Rethinking collegiality: re-stratification in English general medical practice 2004-2008.	November 2005 to May 2006.	Qualitative study: ethnography. Juxtaposed with interviews and observation meeting at the PCT level.	Two practices North West of England, one "Big practice" with registered lists of 12,000 and "Medium practice" patients 8,000. Juxtaposed with the PBC study involved 5 consortia in 3 PCTs during 2007/08.	12 GPs, nine nurses, four health care assistants, one senior receptionist. Juxtaposed with A total of 46 interviews with individuals from consortia, PCTs and partner organizations as well as 68 observations several admin. meetings.	'GPs now appear to accept that quality can be measured and the provision of evidence-based targets and guidelines is viewed by many as assisting them to deliver a quality service.'
McDonald, R., et al. (2009).	Practice nurses and the effects of the new general practitioner contract in the English National Health Service: The extension of a professional	February and August 2007.	Qualitative semi-structured interview study.	One nurse was selected from 20 practices across England.	20 practice Nurse (PN).	PN describe their work as increasingly governed by standardized templates and protocols, posing problems and opportunities in regards to their professionalism.

	project?					
McGregor, W., et al. (2008).	Impact of the 2004 GMS contract on practice nurses: a qualitative study.	12–18 months after the implementation of the new GMS contract.	A qualitative approach, sampling practice nurses from practices in areas of high and low deprivation, with a range of QOF scores.	Glasgow, UK.	18 Nurses.	Nurses increased responsibility. However, discontent about how financial gains are distributed and negative impacts on core values may lead to detrimental long-term effects on motivation and morale.
McLintock, K. et al., (2014).	The effects of financial incentives for case finding for depression in patients with diabetes and coronary heart disease: interrupted time series analysis.	Extracted routinely recorded data from February 2002 through April 2012.	Interrupted time series analysis.	General practices in Leeds, UK.	65 (58%) of 112 general practices shared data on 37 229 patients with diabetes and coronary heart disease targeted by case finding incentives, and 101 008 patients with four other long- term conditions not targeted.	Prescribing trends are of concern given that they may include people with mild-to-moderate depression unlikely to respond to such treatment.
Mitchell, C., et al. (2011).	Impact of the QOF and the NICE guideline in the diagnosis and management of depression: a qualitative study.	Not informed.	Qualitative based on four multidisciplinary focus group.	Comprised five practices after a postal invitation to participate sent to 26 practices in south Yorkshire.	17 general practitioners; 11 practice nurse; Three primary care mental health workers Two STGP registrars Two FP2; Two Community nurses;	The administration of the PHQ-9 interfered with the flow and holistic focus of patient-centred consultation models.

					One manager.	
Norman et al., (2014)	The payment for performance model and its influence on British general practitioners' principles and practice.	June 30th and August 26th , 2011.	Qualitative Semi-structured interviews.	GP representing opinion formers and intellectual leaders in family medicine.	13 general practitioners.	'The British P4P has gradually strengthened a scientific-bureaucratic model of medical practice which has had profound effects on the way family medicine is practiced in the UK'.
Steel, N. and Willems, S. (2010).	Research learning from the UK Quality and Outcomes Framework: a review of existing research.	Up to 26 January 2010.	Systematic literature Review.	Not applicable.	29 studies on the impact of health care; Four on the impact of health professionals; Two on cost impact.	'The evidence base about the impact of the QOF is growing, but remains patchy and inconclusive'.

APPENDIX C – Durham University Ethical Approval

Research Ethics and Data Protection Committee

Department of Anthropology

Science Site, Durham DH1 3LE

Date 25 January 2013

Dear Armando,

NOTIFICATION OF ETHICAL APPROVAL

Re: The Quality and Outcomes Framework - its influence on General Practitioners' principles and practice

I am pleased to confirm that the above research project has been granted ethical permission by the Anthropology Department Research Ethics Committee. You can now start your research.

Approval is subject to the following general conditions:

1. Ethical approval is specific to this Project.
2. If significant changes to the Project become apparent, please notify the Ethics Committee.
3. If any unanticipated problems or adverse events arise that involve risk to participants or others, please report these to the Committee. The Committee may ask you to write a formal report about the problem, and may suggest amendments to your project.
4. After completion of the project, please submit an 'end of project' report which can be found on the DUO ethics pages.
5. Your application has been considered formally at today's Committee meeting, and has been approved.

Best wishes for your research!

Professor Michael Carrithers (CHAIR) cc (Supervisor)

APPENDIX D – NHS Health Research Authority Ethical Comment

Queries NRES (HEALTH RESEARCH AUTHORITY) [nres.queries@nhs.net]
Actions
To: RUSSELL A.J.
Cc: NORMAN A.H.
Inbox

20 December 2012 12:00

ENQUIRY TO NRES

Dear Dr Russell,

Thank you for your further email and summary proposal seeking additional clarity on whether your project should be classified as research requiring ethical review.

As you will be aware, the new harmonised UK-wide edition of the Governance Arrangements for Research Ethics Committees (GAfREC) came into effect on 01 September 2011; detailed changes in the harmonised GAfREC can be foundhere on the NRES website.

There two key elements are whether:

i. your project is research? (The leaflet, *"Defining Research"*, will help you to distinguish between research, audit or service evaluation and public health surveillance.) OR

ii. your project is research requiring ethical review? The algorithm, "*Does my project require review by a Research Ethics Committee?*", is designed to assist researchers, sponsors and R&D offices in determining whether a project requires ethical review by a Research Ethics Committee under the UK Health Departments. It encompasses the requirements for ethical review under both the policy of the UK Health Departments and legislation applying to the UK as a whole, or to particular countries of the UK.
The **Supplementary notes** section, in particular, outlines the types of research that do not normally require review by a REC within the UK Health Departments' Research Ethics Service.

Based on the information you have provided, our advice is that, according to this guidance, the project is not considered to be research requiring review by an NHS Research Ethics Committee.
Advisor's Comments:

I would deem this a service evaluation and hence doesn't need REC review

However, if you are undertaking the project within the NHS, you should check with the relevant NHS care organisation(s) what other review arrangements or sources of advice apply to projects of this type. Guidance may also be available from the clinical governance office.

Where the Research Governance Framework for Health and Social Care applies, the research will continue to require management permission from host care organisations ("R&D approval"). Within the Integrated Research Application System (IRAS), it is possible to indicate in the Filter that a research project requires review by NHS R&D only. Where a

project raises potential ethical concerns, NHS organisations may require ethical review and, exceptionally, NRES would be willing to undertake this review. For student research, most universities will require such a review as part of their normal institutional processes.

All types of study involving human participants should, however, be conducted in accordance with basic ethical principles, such as informed consent and respect for the confidentiality of participants. Also, in processing identifiable data there are legal requirements under the Data Protection Act 2000. When undertaking an audit or service/therapy evaluation, the investigator and his/her team are responsible for considering the ethics of their project with advice from within their organisation.

This response should not be interpreted as giving a form of ethical approval or any endorsement to your project, but it may be provided to a journal or other body as evidence that ethical approval is not a requirement.

Regards
NRES Queries Line
REF 04/26/57

APPENDIX E- Primary Care Trust Research Governance Approval

[redacted]

Research Management &
Governance Unit
NHS [redacted]

Our Reference [redacted]
Your Reference

Direct line [redacted]
Main number
Fax
E-mail

[redacted]

08 February 2013

Dr Armando H. Norman
[redacted]

Dear Dr Norman,

The Quality Outcomes Framework and its Effects on General Practitioners' Principles and Practice
PCT R&D Ref: [redacted]
REC Ref: N/a

Permission is granted by **NHS** [redacted] for the above study to commence in local GP practices, subject to:

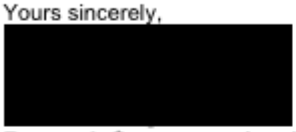
- Any accidents and complaints relating to the research are reported to the PCT(s) through the usual systems.
- Serious adverse events affecting local patients are reported to the PCT(s) promptly.
- The Research Governance Lead is provided with copies of any updated documentation before it is implemented.
- The researchers will provide assistance with any monitoring or audit requests from the PCT(s).

[redacted]

- The research will not require any financial support from the PCT(s), unless there is a written agreement to the contrary.
- The PCT(s) are informed when the project ends.

Best wishes in your research.

Yours sincerely,



Research Governance Lead

Documentation Approved	*Version*	*Date*
IRAS R&D Form	n/a	
CV Norman	n/a	
Protocol	1.0	10/01/2013
Consent form	1.0	10/01/2013
Information sheet professionals	1.0	10/01/2013
Information sheet patients	1.0	10/01/2013
Insurance cover	Durham	

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